MILES & STOCKBRIDGE P.C.

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

June 9, 2015

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

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

Re: Baltimore Nursing and Rehabilitation, LLC
Docket No.
Certificate of Need Application Matter No. 15-24-2366

Dear Mr. McDonald and Ms. Potter:

Enclosed please find six hard copies of the Response to the Completeness Questions and Requests for Additional Information concerning the above referenced 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.

As requested, an electronic copy of the Response will be sent to Ms. Potter in both Word and PDF format.

I hereby certify that a copy of these Responses to Completeness Questions has been provided to the local health department, as required by regulations.

Sincerely,

Jennifer J. Coyne

Enclosures

MILES & STOCKBRIDGE P.C.

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

BALTIMORE NURSING AND REHABILITATION, LLC
CERTIFICATE OF NEED APPLICATION FILED APRIL 10, 2015
MATTER NO. 15-24-2366
RESPONSE TO COMPLETENESS QUESTIONS DATED MAY 11, 2015

PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. Give a prose description to augment the chart labeled Exhibit A. Describe each corporation and its role.

All of the entities listed are owned by Scott Rifkin, Scott Potter, and Howard Friner.

Baltimore Nursing and Rehabilitation, LLC is the operating entity that will: (1) hold the license for the facility; (2) employ the employees of the facility; (3) provide care to the residents of the facility; (4) enter into contracts with residents, suppliers / vendors of the facilities; and (5) seek payment / reimbursement for care.

Baltimore Nursing and Rehabilitation Realty, LLC, (which will operate under the trade name "Restore Health"), is the real estate holding company that will purchase and own the land and improvements. It is only a holding company and will not conduct any operations or own any assets other than the land and improvements. Its only activity will be to lease the facility to Baltimore Nursing and Rehabilitation Center, LLC through a written lease agreement.

Mid-Atlantic Health Care Acquisitions, LLC is a transitional entity used by the owners for business development purposes. This entity will often enter into LOIs and contracts with third party prior to the formation of the operating and real estate holding entities that will actually own and operate the facility. This entity will then transfer the contract rights to the operating entity or the real estate holding company, as appropriate, prior to the closing of the transaction. It is anticipated the this entity would transfer its rights to acquire the bed rights from Bayview to Baltimore Nursing and Rehabilitation Center, LLC prior to closing.

Mid-Atlantic Health Care, LLC is a management company used by the owners to manage the financial, accounting, tax, human resources, and legal functions of the various facilities that are owned by the owners. This entity provides those services to all of the facilities owned by the owners through a Management Agreement between this entity and each operating entity.

2. Question 14C asks for information regarding site control, not the purchase of the beds, which is what Exhibit D documents. Please provide a copy of the purchase option for the site.

A copy of the executed Agreement of Purchase and Sale dated February 13, 2015 is attached hereto as **Exhibit A**. An Amendment to the Agreement of Purchase and Sale has been circulated for signature, but does not change the timing. Closing is initially scheduled for 2/12/16. There are three (3) thirty-day buyer options to extend, bringing closing potentially into May 2016.

PROJECT DESCRIPTION

3. The application states that Restore Health is "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." Please elaborate on that statement and cite specific features and sections of the Act that meet this description.

The proposed facility is designed to be a new model for nursing homes, a model designed to operate more broadly in the continuum of care and more closely integrated with the hospital. It is designed explicitly to serve patients who are currently served in the hospital, thereby shifting volume from the hospital setting to the nursing home setting. This new nursing home model does not currently exist in Maryland. It will be equipped to serve a broader patient population, and it will provide higher skilled staff/service capabilities to reduce reliance on the higher cost hospital setting. Its purposes and its distinct features are defined by the following:

- Restore Health will provide a higher level of care in the nursing home to serve hard to place post-acute patients with distinct treatment requirements or more medically complex needs that area nursing homes historically do not readily accommodate according to discharge planning staff at local hospitals. These are patients who currently experience long discharge delays and, by default, are dependent on the higher cost hospital setting for lack of an alternative. Restore Health will accommodate patients who require the higher skill set, facility accommodations, specialized equipment, and/or support services to meet distinct service requirements that are not currently provided adequately in Baltimore City nursing homes. This will permit hospitals to discharge patients earlier from the hospital, provide rehabilitative/restorative care in a lower cost setting, and reduce readmissions to the hospital. As explained in these Responses, the patients are primarily dialysis, ventilation and bariatric patients.

- Restore Health will be designed to work in close partnership with hospitals and physicians in episode management and bundled payment models. Restore Health will design integrated treatment protocols, support lower cost episode management, and participate in bundled pricing and shared savings models with hospitals and physicians. The HSCRC has explicitly identified bundled payments as one of the strategies that supports the goals of the waiver. Restore Health is prepared to coordinate with Maryland hospitals and with the HSCRC to develop bundling arrangements that support the Maryland Demonstration Model (*See also* Response to Comment No. 4 below.)
- Restore Health will provide a lower cost setting for restorative care in place of current hospital stays that are often extended. Restore Health will function to reduce readmissions to the hospital.
- Restore Health will also provide a lower cost alternative setting to the hospital by providing a safe, high quality, well-resourced inpatient setting for low acuity patients who are currently admitted to the hospital for cardiac monitoring, fluid management, IV antibiotics, complex wound care, or palliative care. Restore Health will serve as a lower cost setting to which these patients may be admitted directly. Patients may be admitted directly from the emergency room or admitted directly from home and thereby avoid hospitalization altogether.[1] Restore Health will function to reduce unnecessary hospital admissions (PQIs) by providing an alternative setting, and will reduce readmission rates. Restore Health will have minimal impact on existing nursing homes because its census will be built from the shift of hospital days to the nursing home, it will substitute hospital days with lower cost nursing home days.
- Restore Health also expects a modest (5%) recapture of area residents who currently leave the area for care.

This new model for a nursing home responds directly to the initiatives established by The Affordable Care Act:

- The Affordable Care Act created the Center for Medicare and Medicaid Innovations (CMMI) which then introduced several initiatives aimed at reducing Medicare and

[1] We recognize that Medicare reimbursement is not currently available for these services, but the facility will not open until CY2018 at the earliest, and commercial payors are increasingly paying for this type of service elsewhere now.

Medicaid expenditures while enhancing the quality of care. One of the payment initiatives developed and implemented by CMMI was the "Bundled Payments for Care Improvement Initiative," designed to align incentives for providers (hospitals, post-acute care providers, physicians and other practitioners), and encourage these provider networks to work more closely across specialties and across settings. *See* https://www.cms.gov.

Under the Bundled Payments Model, profitability is tied to reducing the costs of care, achieved largely by minimizing hospital length of stay and reducing hospital re-admissions. In part, this is achieved by shifting more care to the lower cost sub-acute or home setting, improving continuity of care across settings, and elevating the level of services and quality of care provided in the sub-acute setting. Across the country, bundled payment models are operating, and the HSCRC has explicitly identified bundled payment models as one of the approaches it aims to expand in Maryland. *See* HSCRC Payment Models Workgroup, 6/2/15 http://www.hscrc.state.md.us/hscrc-workgroup-payment-models.cfm ("Encourage . . . [and] enable population-based approaches . . . look to broaden authority for gainsharing, bundled payments, and shared savings for Medicare FFS").

- The Affordable Care Act of 2010 required the establishment of a readmission reduction program. The Hospital Readmissions Reduction Program, made effective in 2012, established a methodology to calculate the expected 30 day readmission ratio for three conditions and allowed CMS to reduce payments to hospitals with excess readmissions. The program was designed to provide incentives for hospitals to reduce the number of unnecessary hospitals readmissions. One of the strategies that hospitals have adopted is to strengthen medical services in nursing homes to better manage patients in the post-acute stage. Restore Health has a strong track record in achieving lower than average readmission rates from the nursing home to the hospital by providing a high caliber of medical services, care management protocols, and effective communications between nursing and medical staff. *See* **Exhibit B**. Finally, readmission rates may be lowered by providing more extended inpatient care for recuperative care after an acute episode. This recuperative care, however, can be

provided at lower cost in the nursing home setting. Restore Health will respond directly to this objective.

Maryland adopted its own readmissions program to incentivize hospitals to reduce readmissions. The Maryland model is much more inclusive than the Medicare model discussed above since it applies to many more conditions and to all patients, not just Medicare.

In addition to the penalties and potential gains under the readmission program, all Maryland acute hospitals currently are under some form of population health program (either the Guaranteed Budgeted Revenue or the Total Patient Revenue program), which is designed to not pay hospitals for any increase in potentially avoidable utilization, including readmissions. In addition, the HSCRC penalizes hospitals if individual hospital and statewide readmission reduction targets are not met. Since the amount of hospital revenue is basically fixed (with limited adjustments for 50% of the age cohort adjusted population increase and market shift), hospitals continue to have incentives to reduce length of stay. However, given that hospitals' revenue is not adjusted for changes for potentially avoidable readmissions (some readmissions are planned and therefore permissible), the old problem of inappropriately quick discharges (the "quicker and sicker" syndrome) is avoided. Unless a hospital has a medically appropriate discharge option (which this application is intended to provide), the hospital may keep patients in the inpatient setting longer to ensure a lack of readmission. Hospitals need an alternative which this Project is designed to provide.

4. On p. 7 the application states: "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." Please describe a) what a "bundle payment provider" is.

As noted earlier, the Bundled Payments for Care Improvement initiative is one of several payment initiatives developed and implemented by CMMI, and has been implemented across the country by hospitals and nursing homes. Under this initiative, organizations contract with CMS under a payment arrangement that includes financial and performance accountability for episodes of care. The Initiative offers four payment models involving hospitals, post-acute care providers, and physicians. The initiative is designed to align incentives across providers and encourage providers across the continuum of care to work closely together across settings.

Under the Bundled Payments model, profitability is tied to reducing the costs of care, achieved largely by minimizing hospital length of stay and reducing hospital readmissions. This

is achieved by shifting more care to the lower cost nursing home setting or home setting, improving continuity of care across settings, and elevating the level of services and quality of care provided in the nursing home setting.

Five of Mid-Atlantic's Philadelphia area nursing homes are participating in bundled payment contracts with Einstein Medical Center, (Philadelphia, Pennsylvania) and affiliated physician practices in Pennsylvania. Together, this group of providers has contracted with CMS for management of selected DRG-defined episodes of care (specifies orthopedics conditions, etc.) under a fixed payment for the episode of care. This fixed payment covers the costs of the entire episode of care to include hospital care, physician care, nursing home care, and home care. The provider group works to achieve a lower cost per episode through more effective care management, reliance on lower cost service setting, reduction in unnecessary utilization, and improvements in quality of care. Any savings achieved relative to the contracted payment rate is shared with CMS and providers. As a provider participant in this Initiative, Mid-Atlantic has gained experience with working partnerships and effective care management strategies, and will bring this experience to delivery systems in Maryland.

Currently, Maryland hospitals cannot participate because they are not "subsection (d)" hospitals, (hospitals that are paid under the inpatient prospective payment system used in the rest of the country). We note that the proposed facility is not anticipated to be open until 2018. A new agreement with CMS will be required when the current five year agreement with CMS ends in 2018. We have been informed that the State will ask for an exemption to permit bundled payments at some point as part of contract discussions/contract development with CMS. In the interim, Mid-Atlantic continues to gain experience with Medicare and managed care in the Philadelphia area facilities.

5. The application makes the following statement: *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%.*

a) Regarding the prospective direct admits to the nursing home, what payor(s) are committed to cover that?

Mid-Atlantic is in discussion with some of the major payors with respect to direct admits, using its experience in Pennsylvania as evidence of the value-added features to this model. To date, specific contracts have not been entered into, which is understandable given the time period to opening and the fact that this application has not even been docketed. In addition, the "alternative rate methodology" (ARM) construct already exists under the HSCRC as an opportunity for MAHC to partner with a Maryland hospital to submit a proposal.

b) Define what you mean by "Mid-Atlantic's readmission rate."

MAHC defines its readmission rate as all MAHC residents that have an unplanned readmission to a hospital within 30 days from of discharge from a hospital divided by all admissions to MAHC nursing facilities that had a hospital stay within the last 30 days prior to admission. MAHC tracks this all cause readmission rate for the total nursing population (all payers).

c) Please document that rate, as well as the source of Maryland's rate of 25%

Performance reports for MAHC facilities demonstrate the following readmission rates for CY2014:

MAHC 30-Day Readmission Rate
All Cause, All Payers
CY2014

Maryland facilities (6)	15%
Pennsylvania facilities (5)	15%
Delaware facilities (1)	14%

Source: MAHC

The DelMarva Foundation of Maryland issued a report titled "ICPC Quarterly Scorecard, 2009-2012" that includes performance indicators related to readmissions across various settings. Included in this report is the 30-day readmission rate of all patients discharged to skilled nursing facilities. The 30-day readmission rate for skilled nursing facilities in Maryland in CY2012 is reported as 23.2%. (Source: *DelMarva Foundation*, *"ICP Quarterly Scorecard, 2009-2012"*, Appendix 2, page 141). For additional information, see **Exhibit C**, which contains selected portions of ICPC Quarterly Scorecard, January 1, 2009 to December 31, 2012, Maryland, published by Delmarva Foundation, QIO (June 1, 2013).

6. What is the projected distribution of beds between residential care and short stay patients?

The fifth and sixth floors of the building are designed to be dedicated primarily to shorter stay residents. These floors consist of 48 private rooms consisting of 48 of the 80 beds or roughly 60% of the facility. The fourth floor (24 rooms - 32 beds) is designed for longer term care residents. However, longer stay (80-90 days) patients will be assigned to the fifth and sixth floors as appropriate. See page 8 of the Application for additional information.

PROJECT BUDGET

7. Is the cost of renovating the 2 floors of the proposal that are not part of the proposed CCF included in the project budget? If not, resubmit to include that in the "cost of other areas" column. Is the intent for the entire facility, including the non-CCF space, to be included in the CON total cost?

As discussed at our meeting on May 19, 2015, the project cost includes total costs for the CCF and all the mechanical and plumbing, etc. needs for all floors of the building, including new stairwells. We have not included the cost to create a shell space for those floors as we are in discussions now over what that space might need given potential tenants. As per our agreement at the meeting, we will continue to omit the build out costs for these floors. See page 12, which notes there are 867 square feet of renovated space on the two floors. While those costs associated with the project are included, such as a new stairway, the cost to demo and create a shell space is not included. Please see **Exhibit D** for a revised Project Budget reflecting "cost of other areas" data.

8. Will there be interest cost during construction that is not reflected in this budget?

We have added expected interest during the construction period of $630,000. This assumes a $13.9 million loan at 4.5% interest for one year. This cost is added to project costs and becomes an additional item covered under the project financing. Any interest incurred after the facility opens is captured in the operating losses. The updated Table C is attached as **Exhibit D**.

9. Is bed purchase reflected in the budget? Doesn't appear to be.

No, the bed purchase of $550,000 was not included in the budget. We have included the costs in the attached revised total project budget in Table C as an "other expense". See **Exhibit D**.

10. The calculations presented in Table G (Revenue and Expense projections) are premised on proportions of Medicare and Medicaid patient-days (42% Medicare/47% Medicaid) that are vastly divergent from the city-wide average, which was 15.25% and 73.68% respectively. Please:

    a) Explain why this proportion is a reasonable assumption.

We based our payor mix on the payor mix at Fairfield Nursing and Rehabilitation, another MAHC facility in Maryland, similarly positioned in Crownsville, MD. Crownsville is located in Anne Arundel County which is also part of the Central Maryland jurisdiction. This facility maintains a focus on short stay rehabilitation in similar fashion to the proposed facility. The Crownsville facility reports the following a payor mix for 2014:

Payor	Days	% Of Days
Medicaid	14,018	44%
Medicare Part A	13,213	42%
Private	3,034	10%
Managed Care	1,310	4%
Total	31,575	100%

    b) Produce a revenue and expense statement for CY2021 showing alternative scenarios that assume a Medicare/Medicaid mix closer to the city norm. For these purposes, use the assumptions shown below.

Scenario	Medicare patient-days %	Medicaid patient-days%	Commercial insurance patient-days%*	Self-pay patient-days%*
Scenario 1 (as in application)	42.0%	47.0%	6.0%	5.0%
Scenario 2	20%	69%	6.0%	5.0%
Scenario 3	23%	66%	6.0%	5.0%
* If modifying the Medicare, Medicaid assumptions would affect assumptions for commercial insurance and/or self-pay, feel free to make those modifications, but explain the rationale for any such assumption change.				

A revenue and expense statement for each of these scenarios is attached at **Exhibit E**.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY

11. Exhibits H and I: Please provide an actual-sized, unblurred set of these documents. Also, these exhibits do not document the statement that "the bans were lifted and both facilities are now in full compliance." Such documentation should be provided.

Attached collectively as **Exhibit F** are new copies of former Exhibits H and I. Attached as **Exhibit G** is a letter dated September 19, 2013 demonstrating that the Delmar Nursing and Rehabilitation Center regained substantial compliance with Federal participation requirements as of September 18, 2013.

Attached as **Exhibit H** is a letter dated December 15, 2014 demonstrating that Villa Rosa Nursing And Rehabilitation, LLC had regained substantial compliance with Medicare requirements as of December 10, 2014.

12. Please describe the nature of the deficiencies at Villa Rosa and Delmar, any harm that occurred, and what corrections were made.

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. Specifically, based upon observation and discussion with the maintenance supervisory, 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. In addition, the State Fire Marshal observed that ground fault protection was to be installed in all bathrooms and shower rooms where electrical devices were in close proximity to a water source. Proposals for the work had been acquired, but no contract was signed and no work had been started. No harm occurred. All corrections were made. Substantial compliance was regained. (*See* Exhibits F, 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. No harm occurred. All corrections were made. Substantial compliance was regained. (*See* Exhibits F and G.)

CONSISTENCY WITH GENERAL REVIEW CRITERIA (COMAR 10.24.01.08G(3))

a) The State Health Plan

A. General standards

Nonelderly Residents

13. The application did not address part (a) of this standard *referencing training in the psychosocial problems facing nonelderly disabled residents*.

MAHC serves nonelderly disabled residents at all of its facilities. All employees of MAHC facilities are required to complete 30 hours of online training each year. One of the training modules specifically focuses on age specific care. We have included the course description in **Exhibit I**.

Facility and Unit Design

14. The response to this standard is quite descriptive of the planned environment but should more explicitly address how the described features fit or are tailored to the expected patient population(s). As the standard says, *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.* Any literature supporting the planned design features should be cited.

As stated in the original application, 89% (64 of the 72 rooms) of the patient rooms will be private. The advantages of private rooms are well accepted, but we have attached an article as **Exhibit J** which discusses the psychological and clinical advantages to private rooms. The article cites the positive resident experience and the psychological effect associated with privacy, and highlights several studies that document lower rates of infection associated with private rooms. The article also mentions greater family satisfaction and privacy when visiting their loved ones in facilities with private rooms which helps both long term and short stay resident families. Finally, it also suggests that greater privacy enabled better adherence to HIPAA regulations.

From a regulatory standpoint, the facility's rooms are designed to be at least double the required square footage by COMAR for a private or semi-private room. According to COMAR 10.07.02, a private room must be at least 100 square feet per bed and a semi-private room must be at least 80 square feet per bed. The average private room in the facility is 318 square feet which is over three times the required size. These rooms range in size from 245 square feet to 428 square feet. The average semi-private room in the facility is 378 square feet which is over

2.3x the requirement. Semi-private rooms range from 317 square feet to 479 square feet, so even the smallest rooms are 1.5 times larger than required.

Larger room sizes enable the facility to serve specific patient populations. For example, bariatric patients require larger beds. Specifically, MAHC uses Invacare BAR750 beds which measure 48 in x 88 in versus MAHC's normal Invacare Carroll CS Series CS7 bed which measures 36 in x 80 in. The footprint of a bariatric bed therefore requires as much as 10 square feet of additional floor space. Rooms designated for bariatric residents also require larger bathrooms and space for additional equipment to be rolled in including lifts to aid the care staff to remove the resident from his/her bed. In addition, these rooms will include wider, double doors to allow easier access. Other patient populations will enjoy similar benefits, such as ventilator and dialysis patients who require bulky medical equipment by the bedside for their care.

The design of the facility also promotes a "neighborhood model" as discussed in **Exhibit K**. Neighborhood models attempt to create a more home-like setting and promote greater interaction among residents and increased patient satisfaction. Each of the top two floors has 24 rooms creating its own neighborhood which includes a central activity/dining space that features café style dining. MAHC used this design feature at its Waldorf facility, pictures of which were included in the original application. This style of food preparation includes a central kitchen which makes all the food which is then delivered to the cafes where it is served individually to each resident from hot warming stations. At our Waldorf facility, feedback has been very strong form our residents as it allows residents to see their options and pick and choose their own meals. Again, these features enhance the experience for both short stay and long term care residents of the facility.

Collaborative Relationships

15. The application refers to a collaboration with UM Medical School which would be *"about integrating clinical pathways to advance the care of the patients and promote new research opportunities to determine optimal care plans."* This concept is introduced in the project description in which the application envisions creating *"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 "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."* Please:

a) Identify the new reimbursement models referenced, and document an ability to participate in them.

Current environment – As described in the responses to Questions 3 and 4, the Affordable Care Act launched a number of new payment models including bundled payments and specialty episode management, and also spurred the very progressive, broad-based hospital financing model introduced in Maryland (referred to as the "new waiver" model). While bundled payment contracts have not been yet implemented across hospitals and nursing homes in Maryland, nursing homes in Maryland are effectively engaged in the GBR model through closer working relationships with hospitals, care transition programs, and readmission reduction programs. Several hospitals in Maryland are funding additional medical manpower in nearby nursing homes, and expectations are that when bundled payment models are introduced, there will be the opportunity to structure shared savings models across acute, post-acute, and physician providers. The HSCRC – in its presentation material – specifically identifies bundled payment models as an opportunity area that might include cardiology, cardiac surgery, orthopedic surgery, vascular surgery, other medical conditions, and other surgical procedures.

Future environment – The State of Maryland is currently operating in Phase I of the Demonstration Model; Phase II is scheduled to begin in 2019. This is the more relevant landscape for the proposed project, as Restore Health is not scheduled to open until 2018. At that point, Maryland would be expected to operate under per capita total health care spending targets. In this context, the total costs of care will be the relevant metric, including outpatient, acute care, and post-acute services. Restore Health will be well-positioned to support cost-effective service delivery and episode management for successful performance under this new waiver, in which case delivery in the lowest cost but care appropriate setting is crucial.

b) Document the potential partnerships with acute care hospitals referenced.

The original CON application included a letter of support from the University Of Maryland School Of Medicine. MAHC and the University of Maryland School of Medicine are discussing relocating and consolidating all the outpatient medical practices of the physicians into the building to be located on floors 1 – 3. This proximity will more easily allow the physicians to visit patients located in the facility and to better enable collaboration and care for these residents.

MAHC has also included a letter of support from the University of Maryland Medical Center Midtown Campus (UMMC Midtown) (**Exhibit L**). MAHC and UMMC Midtown are analyzing how to better coordinate care for patients discharged from the hospital to help better manage readmissions to the hospital. Additionally, we are analyzing how this collaboration can help to avoid certain hospitalizations as well.

c) Identify the "touch point" with patients that will position and enable the applicant to achieve this?

In addition to the relationship with the School of Medicine discussed above, Mid-Atlantic will coordinate closely with discharge planners and social workers at both hospitals to develop tools that will assist in care coordination.

B. New Construction or Expansion of Beds or Services

Bed Need

16. There are many sweeping, undocumented, and un-quantified assertions made in this section attributed to "hospitals" and "case workers" and "case managers" regarding the needs of specific patient populations and needs (e.g., dialysis, medical monitoring after acute cardiac episode, patients with Left Ventricular Assisted Device, bariatric patients). For these claims to receive any weight in a review, documentation and quantification will need to be provided.

05A (1) Bed Need - *Nursing home volume for Baltimore City residents has increased considerably* – Between 2009 and 2013, the number of nursing home discharges for Baltimore City residents has continued to increase as documented below:

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
Summary data obtained through the Maryland Health Care Commission (April 2015)

In CY2013, more than 2,800 nursing home placements for Baltimore City residents, age 65 and above, were arranged at facilities outside of Baltimore City despite the availability of beds at nursing homes in Baltimore City - This reliance on out of area nursing homes is likely an indicator that service needs are not currently being met by existing nursing homes in the local jurisdiction:

Nursing Home Discharges of Baltimore City Residents
Distribution by Nursing Home Location
Patients age 65+ years
CY2013

	Number of nursing home discharges at facilities in:		
Patient Residence	**Baltimore City**	**Outside Baltimore City**	**Total Nursing Home Discharges**
West Baltimore	1,679	1,300	2,979
East Baltimore	1,135	649	1,784
North Baltimore	1,124	908	2,032
Total Baltimore City residents, Age 65+ Discharged from nursing homes	3,938	2,857	6,795
Distribution of placements across Maryland facilities	57%	42%	100%

Percentage of City residents served at Maryland nursing homes outside Baltimore City = 42%

Source: Long Term Care Minimum Data Set
Summary data obtained through the Maryland Health Care Commission (April 2015)

17. Similarly, the claim is made that 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*" (p. 27). Please:

a) Be specific about the services, staff capabilities, and facility design contemplated;
b) Document the reports from area hospitals re: these needs.

a) See Response to Question 14 above.

b) Based on the fact that Restore Health expects to operate in very close collaboration with the University of Maryland Medical Center and University of Maryland Midtown Campus, discussions were held with the Directors of Case Management and Social Work at each hospital, as well as their professional staff members, to identify the greatest gaps in nursing home care and the patient volume associated with these difficult-to-discharge patient populations.

Social workers and case managers identified specific service requirements and staff capabilities that are in insufficient supply in the region, and a shortage of bed capacity for particular patient populations; these gaps result in discharge delays, unnecessary hospital days, higher costs of care, and higher risk of hospital infection. In addition, patients who are awaiting rigorous rehabilitation program have their therapy regimens delayed; the hospital typically provides only limited rehabilitation services to patients in acute care units, and patient progress can be delayed.

More specifically, social workers and case managers from UMMC and UMMC Midtown Campus identified the following needs for patients who are **otherwise ready for discharge from the acute care hospital but are kept in the hospital because few nursing homes provide the continued supports/treatment needed** (Note: The list below represents those needs that were both *identified by caseworkers* and that *Restore Health expects to meet* in the proposed facility)**:**

- Dialysis treatment
    - While several nursing home facilities provide dialysis in-house or transport to an outpatient facility, the waiting time for a nursing home bed is significant; UMMC caseworkers report typical wait times of 1-3 weeks for a patient who also requires dialysis. This is a function of the following factors:
        - Some nursing homes are "capped" by the number of patients they can accommodate in their transport vehicles for dialysis patients;
        - Some nursing homes/dialysis providers will not accept patients who do not have a secondary payor; and
        - Dialysis providers (private companies contracted to provide dialysis in the nursing home) typically will not accept patients while the "acute renal failure" diagnosis is maintained.
- Dialysis and ventilator care/Dialysis and tracheotomy care
    - Caseworkers at both UMMC and at UMMC Midtown rely on nursing homes in Prince George's County and Anne Arundel County due to lack of capacity more locally that will serve this patient population. Caseworkers at UMMC and at UMMC Midtown report that wait times can be months in the hospital before a nursing home bed becomes available.

- Facilities/equipment accommodations for bariatric patients:
    - While several nursing homes in Baltimore City will accept bariatric patients, capacity is limited by the number of bariatric patients area nursing homes are willing to accept, given the additional manpower required and the space/equipment required to adequately accommodate this patient population. Caseworkers at UMMC and UMMC Midtown report that wait time is variable, but in many cases bariatric patients remain in the hospital for weeks for lack of an available nursing home bed. (*See* Response to Comment on Need for discussion of wait time.)
- Staff skills and/or equipment for medical monitoring/medical treatment for patients who require:
    - NG tubes
    - TPN requirements
    - IV antibiotics
    - IV drips of heart medications for patients with heart failure
    - Treatment for low magnesium level
    - Continuous fluid exchange; requirement for wall suction
    - Close monitoring and daily lab reporting for post-transplant patients.
- Dialysis care and ventilator management; dialysis and tracheostomy care – Currently, there are insufficient nursing homes in Baltimore City that accommodate this need and only limited capacity exists at nursing homes in neighboring counties. UMMC typically discharges patients with these service needs to the chronic unit at UMMC Midtown for continuing care.
- Caseworkers consistently noted that even among those patients who *are* discharged to nursing homes, many could be discharged to nursing homes *earlier* if the receiving nursing home were equipped to accept patients requiring:
    - IV antibiotics;
    - NG tubes.

18. Reference is made to "*the working partnerships between Mid-Atlantic and the University of Maryland Medical System" which "is expected to result in an increase in referral volume to*

the post-acute setting" (p27). Please describe that working partnership and provide a letter from this partner validating the assertions made.

Please see the attached letter of support from Brian Bailey at University of Maryland Mid-Town at **Exhibit L.**

19. The application alludes to waiver of the 3-day hospital stay rule, and that such a waiver will result in more referral volume and direct admits. Research by the MHCC staff and consultation with both MHA and HSCRC yields no evidence that such a waiver is likely in the near term. Please comment.

Reference to waiver of the 3-day hospital stay rule reflects the direction anticipated for CMS policy. CMS has already demonstrated a willingness to waive the 3-day hospital stay rule in context of alternative payment and delivery initiatives in other states: The 3 day hospital stay rule has been waived alongside (a) the Pioneer ACO program and (b) bundled payments models, where implemented. While Maryland hospitals have not been permitted to participate in these specific two initiatives to date, expectations are that the 3 day rule will be waived in Maryland in the future alongside the following initiatives:

- "Next Generation ACO's" – This new initiative has only recently been announced by CMS, (see **Exhibits M and N**), available to applicants who have already established ACOs of 10,000 plus enrollees, and the HSCRC is considering pursuing implementation in Maryland. The terms of the new model explicitly state that CMMI would consider waivers of CMS rules, and a waiver of the 3 day hospital stay rule falls within that statement. Therefore, if this model were implemented as a stateside construct, the 3 day hospital stay rule would be waived. A summary of features/terms of the model is presented through both CMS' slide presentation (**Exhibit N** (pp. 33-36)), and a short article summarizing the initiative (**Exhibit M**). Should the state of Maryland be successful at establishing this model, the 3 day waiver would be granted beginning January 2017, one year *before* the opening of Restore Health.
- Maryland Demonstration Model, Phase II – In the initial waiver discussions, the State of Maryland requested waiver of the 3 day hospital stay rule, but this term was not approved. It is anticipated that waiver of the 3 day hospital stay rule will be proposed for Phase II of the Demonstration Model, and it is more likely to be approved in context

of Maryland's total per capita health care spending construct that will be imposed at that time.

We understand that there is no near term waiver in the discussion. Health reform is not going away, so this is the direction in which the State is moving. Our near term is 2020-2021. The first full term calendar year would be 2018. In health care, the choice is to build based on the past or build for the future. This Project is built for the future.

20. With regard to the relocation of these beds, the application states as a rationale that relocating these temporarily de-licensed beds to a location proximate to "*three hospitals that demonstrate some of the highest demand for post-acute placements of complex patients"* accounting for more than 5000 sub-acute placements in CY14. Yet applicant did not show that these facilities had any difficulty placing those 5000 patients; by definition, they were placed. Please elaborate on and document unmet need for subacute placement.

While more than 5,000 total nursing home placements were arranged in CY14, this figure does not indicate the number of patients who remained in the hospital for lack of placement and does not indicate the number of unnecessary hospital days associated with delays in placement due to limited availability of beds for patients with distinct service needs. Therefore, the fact that 5,000 placements were arranged is not evidence of adequate supply. It is an indicator of the patient volume that is successfully discharged eventually, but it is not an indicator of the patient volume that could not be placed, more timely placed, or placed within the community. Mid-Atlantic has submitted the evidence of **unmet** bed need, (*see* p. 27 of the Application and throughout the Completeness Questions), which is not reflected in the number of successfully placed patients. The evidence provided includes data documenting:

- Discharge delays associated with lack of an available post-acute bed for patients requiring dialysis;
- Discharge delays associated with lack of an available post-acute bed for bariatric patients; and
- Estimated number of acute care days for patients who could have been discharged to a post-acute transitional setting if area nursing homes provided higher skilled/better resourced staff to serve the more complex patient. This Project is intended to meet this need.

21. The application states that "many patients must be transferred to nursing homes outside their community, reflecting the limited choices available for West Baltimore residents." Please document this.

In CY2013, more than 2,800 nursing home placements for Baltimore City residents, age 65 and above, were arranged at facilities outside of Baltimore City (42% of total nursing home discharges for City residents) despite the availability of beds at nursing homes in Baltimore City. This pattern is consistent for the West Baltimore community, as well: A total of 1,300 discharges for West Baltimore residents (44% of total nursing home discharges of West Baltimore residents), were made to nursing homes outside Baltimore City. As the MHCC has noted, nursing home beds are available in Baltimore City. This reliance on out-of-area nursing homes by 42% of the patients discharged is an indicator that service needs are not currently being met by existing nursing homes in the local jurisdiction, and that need in the City exists.

Nursing Home Discharges of Baltimore City Residents
Distribution by Nursing Home Location
Patients age 65+ years
CY2013

	Number of nursing home discharges at facilities in:		
Patient Residence	**Baltimore City**	**Outside Baltimore City**	**Total Nursing Home Disch**
West Baltimore	1,679	1,300	2,979
East Baltimore	1,135	649	1,784
North Baltimore	1,124	908	2,032
Total Baltimore City residents, Age 65+ Discharged from nursing homes	3,938	2,857	6,795
Distribution of placements across Maryland facilities	57%	43%	100%

Percentage of City residents served at Maryland nursing homes outside Baltimore City = 42%

Source: Long Term Care Minimum Data Set
Summary data obtained through the Maryland Health Care Commission (April 2015)

22. The preceding set of questions leads up to this summary question regarding need: Given that the bed need projection promulgated by MHCC shows Baltimore City to have a surplus of 500 beds (unadjusted bed need of -120 and a community-based services adjustment of 380) – accompanied by a jurisdictional occupancy rate of 87.8% -- why is this facility needed?

The facility is needed for at least four reasons:

#1 "Surplus" beds do not meet the need – Social workers and case managers report the gaps in meeting distinct service needs and cite the shortage of beds for certain patient populations. The fact that there is excess capacity of licensed nursing home beds does not help if existing nursing homes will not admit or cannot properly serve these patient populations. Therefore, current occupancy rates are not an indicator of need; existing nursing homes, in large measure, do not accommodate whole categories of patients defined by specialized care needs, and *those nursing homes that do serve these patients populations typically operate at maximum capacity for these patient populations (e.g. care for bariatric patients)*. The need for the proposed facility is to:

a. Serve patients for whom there is a shortage of available beds (dialysis; bariatric; TPN; complex wounds; NG tubes);

b. Serve patients who are not being served at all by existing nursing homes due to more medically complex or specialized care requirements (e.g. post-transplant patients);

c. Serve low acuity patients (who are now treated in hospitals) in the nursing home; substitute the lower cost nursing home setting for the higher cost hospital setting. Admit patients directly from the ER and directly from the community, and reduce PQIs and readmissions to the hospital. (Near-term: Non-Medicare patients / Longer-term: Medicare patients); and

d. Provide local area nursing home capacity for the patient populations above to minimize the reliance on out of area facilities – By providing additional capacity for these patient populations, the proposed facility will improve local access and minimize the hardship to families with family members admitted to nursing homes outside the City.

#2 The projected population for the elderly cohort will result in a significant increase in demand for nursing home care in Baltimore City facilities – Between Year 2013-2019, the elderly population of Baltimore City is projected to grow by nearly 7%.

Baltimore City Population
2013-2019

	2013 Actual	2019 Projected	# Difference	% Change
< Age 65	546,682	551,929	5,247	1.0%
Age 65+	75,422	80,419	4,997	6.6%
TOTAL	622,104	632,348	10,244	1.6%

Source: Maryland Department of Planning

Assuming stable use rates for nursing home care, and stable distribution patterns across nursing homes in the state, this would translate into an increase of 214 occupied nursing home beds at Baltimore City nursing homes by Year 2019 (see below). Even if one were to assume a 1% /year decline in days per 1,000 (through greater reliance on community-based settings), the population growth would still drive the need for approximately the same number of occupied beds at Baltimore City nursing homes, *and this would not include the many extended functions proposed for this new facility*.

Nursing Home Utilization
By Baltimore City Residents, Only
2013-2019

	2013 Actual	2019 Projected @ stable use rate	2019 Projected @ 1%/yr use rate decline
Total population	622,104	632,348	632,348
# Nursing home days	1,412,182	1,490,204	1,402,997
# Nursing home days/1,000	2,270	2,357	2,219
Number of Occupied Beds	**3,869**	**4,083**	**3,844**

Note: Use rates reflect age cohort-specific calculations; use rate decline applied to each age cohort

Sources: (1) Population: Maryland Department of Planning (2) Nursing Home Utilization: Long Term Care Minimum Data Set obtained through the MHCC (April 2015)

#3 Lower cost service settings should be encouraged and facilitated. As noted in the CON application, the differential between the Medicare per diem at referring hospitals in West Baltimore relative to the projected revenue per day at Restore Health is dramatic. Substituting nursing home days for hospital days would result in a significant difference in

the costs of care. Under the GBR model, this would make hospital budget dollars more available for reinvestment in the West Baltimore community.

Per Diem Differentials
Hospital: 2014 Actual
Restore Health: Projected

	Medicare per diem	Projected revenue per day
University of Maryland Medical Center		
Medical/Surgical Rate	$1,184	
Observation Rate (daily)	$2,014 ($84/hour)	
University of MD Midtown Campus		
Medical/Surgical Rate	$1,390	
Observation Rate (daily)	$1,692 ($70/hour)	

Restore Health Per Diem	
Medicare	$ 534
Managed Care	$ 375
Private	$ 290
Medicaid	$ 275

This higher skilled, better resourced, and care management-focused facility will function to reduce readmissions to the hospital – Mid-Atlantic's nursing homes operate with protocols for effective communications between nursing and physician staff, and protocols for symptom management in the nursing house (vs. transfer to the hospital emergency room). Readmission rates at MAHC's nursing homes in other markets are relatively low. See also, Response to Question 5.

Jurisdictional Occupancy

23. In addressing this standard, the application posits (in addition to presenting some data on jurisdictional occupancy not exactly in alignment with data collected in the MHCC Long Term Care Survey, likely due to looking at different reporting periods) that *"the jurisdictional occupancy (provision) 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."* The

applicant should note that it cannot be assumed that every bed in the current inventory is fully needed or would be needed at a new site. Historically, when applicants have applied to move beds from one site to another, the Commission has asked the applicant to demonstrate need. Applicants should do this by demonstrating unmet needs; presenting utilization trends for the past five years; and showing how access to, and/or quality of, needed services will be improved. Please state why the jurisdictional occupancy standard should be not applicable (or over-ridden) in this case.

First, it is important to note that nursing home discharges for Baltimore City residents have been increasing, as documented below.

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
Summary data obtained through the Maryland Health Care Commission (April 2015)

Second, please see the response to questions 20 and 24, and the Bed Need analysis in this Response.

Location

24. Please address this standard, which asks an applicant for the relocation of a facility to quantitatively demonstrate how the new site will allow the applicant to better serve residents than its present location. The response in the application, which is: "See the response to 10.24.08.05C(1)(a) and (b) *supra*)" does not lead anywhere.

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

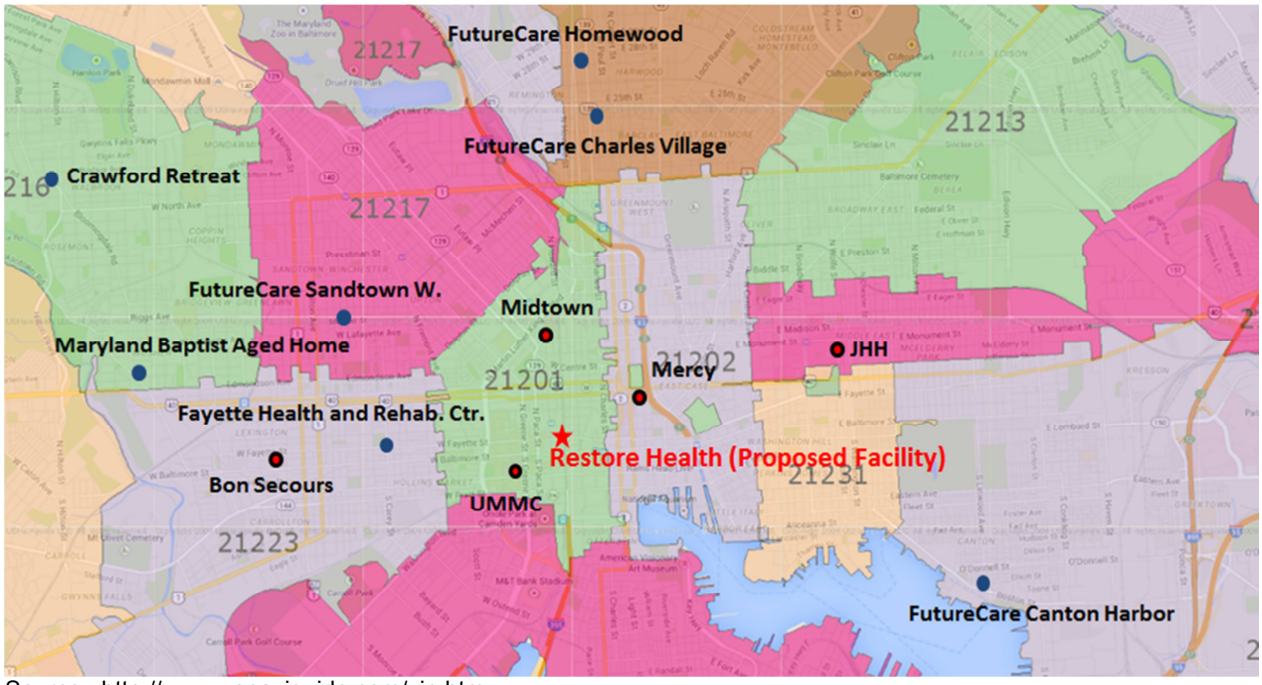
- More responsive to the unmet needs in West Baltimore;
- Directly supportive of new care management models at the two local UMMC hospitals in the West Baltimore community; and

- 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 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.

Map of Proposed Facility



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

The proposed location provides the opportunity to elevate the level of care and treatment capabilities through working relationships with the 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.

(b) Need

See question 15, as much of what is presented to address this criterion was previously – and not incorrectly – presented in addressing that standard. To reiterate, sweeping unattributed, un-quantified, and undocumented statements such as those shown in the table below should be documented and quantified if the applicant wishes them to receive consideration.

Statement	**Page #**
Reports indicate that hospital patients requiring dialysis currently experience long delays until placement can be arranged; there is limited capacity at area nursing homes	40
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.	40
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	40
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.	41

Based on the fact that Restore Health expects to operate in very close collaboration with the University of Maryland Medical Center and UMMC Midtown Campus, discussions were held with the Directors of Case Management and Social Work at each hospital, as well as their professional staff members, to address the following questions:

(1) What are the greatest gaps in nursing home care? What defines the patient populations, the service requirements, and the barriers that result in unnecessary hospital days?

(2) How many patients and how many unnecessary hospital days are associated with discharge delays? On a sample day, how many patients are in the hospital awaiting discharge (number of patients, by category of service need and/or by category of barrier)?

(3) If a nursing home were to provide the more skilled staff capabilities, facility accommodations, resources to meet the more complex cases, and readiness to transport patients to the hospital for treatment protocols, what impact would this make on discharge delays and/or admissions?

(4) If the nursing home were to permit/accommodate direct admissions (from the emergency room and from the community), what patient care needs might it meet, and what volume shift might there be? Would this be valuable?

Discharge delays were variable, and it was not possible for the departments to document the administrative days associated with the subcategories of patient populations. Instead, caseworkers were asked to estimate the number of patients discharged to nursing homes per

month (in these hard-to-place categories), and the number of patients per month that experience discharge delays. Findings are highlighted below and summarized in a table following:

FINDING 1: Shortage of nursing home beds available for specific patient populations; patients remain in the hospital by default:

Dialysis patients

There is a severe shortage of nursing home capacity for Baltimore City residents who require both dialysis and ventilator care or require dialysis and have a tracheotomy.

- The Director of Case Management and Social Work at the University of Maryland Midtown Campus reports that caseworkers rely on three nursing homes in Anne Arundel County and Prince George's County for patients of this profile who require nursing home care, facilities that are typically a significant distance from patients' families.

There is limited capacity to serve dialysis patients who require nursing home care.

- There are only a limited number of nursing homes in Baltimore City that will provide dialysis on site or will transport patients to dialysis units. However, those facilities that do provide patient transport to outpatient dialysis facilities are often "capped" by capacity of the transport vehicle.
- Patients ready for discharge who also require dialysis care also face barriers from private dialysis companies that will not serve patients in the nursing home until the "acute renal failure" diagnosis is removed.

There is a significant volume of hospital patients who need nursing home care and dialysis treatment:

- Caseworkers at the UMMC Midtown Campus reported **44 placements this past year arranged for patients requiring both dialysis and ventilator/tracheotomy care (** and an additional 85 placements arranged for patients who required dialysis. However, wait time before placement has been 1-3 weeks until a nursing home bed is available.
- Caseworkers at the University of Maryland Medical Center estimated that approximately 120 placements were arranged for patients requiring dialysis and ventilator care, and an additional 240 placements were arranged for patients requiring dialysis alone (estimates, only). Almost half of the dialysis referrals were reportedly delayed considerably by lack of an available bed.

- Figures represent estimates and were reported verbally; documentation was not made available to document total annual volume at UMMC.

- At both hospitals, dialysis patients routinely experience significant discharge delays as they await placement; caseworkers at both hospitals reported one to three weeks of unnecessary hospital stays as being typical.

A "snapshot" record of a sample day confirmed this situation. At UMMC, caseworkers estimated there to be two patients who require dialysis awaiting placement on any given day, and at UMMC Midtown, there was one dialysis patient awaiting placement (these are non-acute, unnecessary hospital days, referred to as administrative days to the hospital).

Bariatric patients

There is very limited nursing home capacity to serve bariatric patients relative to the demand for beds.

- Hospital caseworkers at UMMC and UMMC Midtown emphasized that even those facilities that do accept bariatric patients typically limit the number of bariatric patients they accept given the demands that this patient population places on staff.

There is a significant volume of bariatric patients who need nursing home care:

- Social workers at the University of Maryland Midtown campus reported nursing home placements for more than 80 bariatric patients this past year. . Social workers at UMMC estimated approximately 50-60 bariatrics patients per year have required nursing home placement. The large majority of these placements have been accompanied by delays of 1-4 weeks per case (i.e. 1-4 weeks of unnecessary hospital days). (Caseworkers provided verbal reports through discussion sessions)
- A "snapshot" record of 2 sample days at UMMC Midtown indicated that 1-3 bariatric patients were in-house awaiting placement (one of these patients also required dialysis).
    - All three of these patients had been awaiting placement for > 4 months
- UMMC caseworkers estimated 0-1 bariatric patients awaiting placement on any given day as well. See **Exhibit P**, showing unmet demand from Baltimore City hospitals.

FINDING 2: Inability of nursing homes to serve patients who require continued treatment/monitoring/higher skilled care; length of stay in hospital is extended

unnecessarily - Patients who are ready for discharge from the acute care setting but who require continued monitoring/treatment in an inpatient setting remain in the hospital because most nursing homes are not equipped to provide the distinct services/skill level required

- Distinct capabilities that would permit earlier discharge and reduction in administrative days include care of patients with the following needs:
  - NG tubes
  - TPN
  - IV antibiotics
  - Treatment for low magnesium level
  - Complex wound care (*)
  - Fluid drainage/wall suction
  - Drips for heart failure patients
  - Measurement of input/output
  - Post-transplant care
  - Daily transport to hospital for radiation therapy

Caseworkers at both of these hospitals reported that few, if any, area nursing homes will accept patients with these care requirements.

Caseworkers at these 2 hospitals estimated the following volume of patients:

- Caseworkers at the University of Maryland Medical Center estimate that approximately 200 cases per year could be discharged sooner *for transfer to the nursing home* or *discharge home* if higher skilled staff were provided and these distinct treatment capabilities were provided in the nursing home (see list above). Currently, this volume is not reflected in nursing home utilization statistics because these patients are not accommodated in nursing homes.
  - Worth noting is the very significant number of transplant patients in this group. UMMC caseworkers report that more than 30 transplant patients per year could be discharged earlier and transferred to a lower cost service setting for recuperative care if a nursing home provided higher skilled staff and ancillary supports. Transplant volume is expected to grow at UMMC, and this post-acute support will be increasingly valuable.

- Assuming a 14-21 day nursing home length of stay, this would translate into approximately 10 occupied beds accounted for by one referring hospital, only.

- Caseworkers at UMMC and UMMC Midtown actively seek placement for only a portion of these patients. Together, these hospitals reported an average of 3-4 patients awaiting placement on any given day due to lack of a nursing home that could provide this skill level/treatment capability. See **Exhibit P**.

FINDING 3: Opportunity potential to avoid hospitalization altogether, reduce PQIs, and reduce readmissions:

A huge opportunity is available to serve short stay, low acuity cases at the lower cost nursing home setting, particularly for elderly patients, if the 3 day hospital stay rule were waived.

- Caseworkers at UMMC estimated that at the very least, 200-250 cases/year could be well-served in the lower cost nursing home setting through direct admissions; more specifically, caseworkers referred to direct admissions for (a) urinary tract infections and (b) IV Lasix treatment. Assuming an average length of stay of 4 days, this one hospital alone could support 4 occupied beds for this defined group of patients.

FINDING 4: **Average number of occupied beds associated with discharge delays Caseworkers were asked to report the average number of patients awaiting discharge to a nursing home, and delayed by lack of a nursing home bed to meet their needs. The following figures were provided, reflecting only two hospitals in Baltimore City:**

On a given hospital day:
Estimated number of inpatients ready for discharge, but requiring a nursing home bed
(includes only those categories expected to be served by Restore Health)(FY 2015)

Patient Needs	UMMC	Midtown
Dialysis	2	2
Bariatrics	0-1	0-1
Drips: Heart Failure	1	0
Complex Medical	2-3	0-1
IV Antibiotics	2-3	0
Ventilator and dialysis	2	0
Total	~10	~3

Sources: (1) Director of the Department of Case Management and Social Work, University of Maryland Midtown Campus; (2) Caseworkers, Department of Case Management, University of Maryland Medical Center

Demand Assessment for Restore Health: Framework

Berkeley Research Group (BRG) prepared a demand assessment to provide a "reasonableness test" for MAHC's volume projections, using a framework of the patient populations expected to be served at Restore Health:

Patient Population A: Hard-to-place patients/Bed shortage

This group represents the "hardest to place" patients, patients who currently experience some of the longest delays in discharge. This patient population includes:

- Patients requiring dialysis and ventilator/dialysis and tracheotomy care
- Patients requiring dialysis
- Bariatric patients.

The availability of more nursing home capacity for these patients will reduce hospital days by reducing delays in transfer to the nursing home setting.

Patient Population B: Patients requiring higher skilled staff/distinct treatment capabilities

This group largely represents new transfers to the nursing home, as these patients are generally not served by existing nursing homes. These are patients who can be discharged from the acute care setting, but continue to require the skilled care and facility resources to care for NG tubes, TPN, post-transplant surveillance, complex wound care, and other skilled capabilities.

Patient Population C: Local residents served in out of area facilities

Restore Care can expect that its new facility will come to serve a percentage of existing referrals that are now discharged to out of area facilities.

Patient Population D: Patients currently admitted to UMMC and UMMC Midtown for PQIs

This group of low acuity, short stay patients represent admissions to the hospital that are avoidable; PQIs are one of three categories defined by the HSCRC as potentially avoidable utilization (PAUs). Restore Health can provide a lower cost service setting to meet the needs of many of these short stay patients who, in fact, still need an inpatient, monitored setting for care. Reason for admission may include urinary tract infections, dehydration, and asthma in older adults (see full list of PQIs in **Exhibit Q**). Direct admissions of Medicare patients would hinge

on obtaining a waiver of the 3 day hospital stay; direct admissions of non-Medicare patients could be designed in context of clinical pathways and program models developed by UMMC and MAHC providers.

BRG prepared a demand assessment for MAHC to test the reasonableness of MAHC's projections based on the total volume of patients in Patient Populations A, B, C, and D using the following data:

- Patient Populations A+B: Placements from UMMC and UMMC Midtown:
  - Verbal reports/estimates from caseworkers at UMMC and UMMC Midtown about total placements arranged, by category;
  - Estimated capture rates of 75% for dialysis/vent patients (given shortage of providers).
  - Patient Population A:
    - Estimated capture rate of 10% share of dialysis and bariatric patients (given that other nursing home providers exist to meet some of this demand)
  - Patient Population B: Complex medical
    - Estimates from caseworkers at UMMC and UMMC Midtown about total opportunity potential;
    - Estimated capture rate of 90% (given that existing nursing homes do not provide these capabilities/level of care).
  - These nursing home days will effectively substitute for hospital days, as these patients are served in the hospital today
- Patient Population C: Redirection of 5% of out of area placements
  - Based on 5% of the current number of West Baltimore residents admitted to out of City nursing homes (reflects expectation that a new, local area nursing home will function to retain a % of local residents' volume)
- Patient Population D: PQIs
  - Documented volume from the HSCRC Abstract Database, by hospital, coded with a PQI diagnosis
  - Estimated capture rate of 25% for non-Medicare patients and 50% for Medicare patients.

MAHC supplied assumptions about market share and length of stay for each category to project total volume that Restore would be expected to serve. This "capture rate" was based on a number of premises:

- MAHC will be working in partnership with UMMC in bundled payment models
- MAHC will be working in partnership with UMMC on care protocols to promote use of the lower cost serving setting
- MAHC will be providing one of the few nursing home settings in Baltimore for ventilator and dialysis care, but will be one of many facilities providing dialysis care and care to bariatric patients; MAHC is not aiming to shift market share away from existing providers, but aims to substitute nursing home days for hospital days by reducing discharge delays (i.e. making beds more available where shortages are evident).

Based on these assumptions, BRG prepared a volume projection to test the "reasonableness" of MAHC's projected volume, presented on the page following. This assessment indicates that Restore Health can expect to achieve a census of 71 patients, even absent the waiver of the 3 day stay, and can expect to achieve a census of 76 patients when Medicare patients may be admitted as direct admissions. **This volume projection reflects a minimum census, as referral volume for "hard-to-place patients" from other City hospitals is not included here.** See **Exhibit P** (Table: Reasonableness Test for Projected Volume).

Exhibit Q shows the analysis for cases included in the Prevention Quality Indicator Class.

(c) Availability of More Cost-Effective Alternatives

25. The application states that the proposed facility offers a cost-effective alternative to patients remaining in-hospital longer than necessary or desirable because "Evidence indicates that existing nursing home capacity in Baltimore City simply does not meet the demand for care." Please produce the evidence. Note that MHCC data indicates both a significant surplus of CCF beds and a jurisdictional occupancy that is below 90%.

As stated herein, existing nursing home capacity in Baltimore City does not meet the demand for nursing home placement for the patients to be treated at this facility, as evidenced by the statements of discharge planners and the high percentage of patients discharged to facilities elsewhere.

Social workers at the University of Maryland Medical Center (UMMC) and University of Maryland Midtown Campus (Midtown) consistently report that only a small number of nursing homes in the area will accept bariatric patients and patients who require dialysis, and that bed

availability for these patient cohorts is severely limited. As a result, hospital stays are often extended until a nursing home bed becomes available. See discussion in response to Question 24. These patients are not currently served at a sub-acute facility, and spend unnecessary days in the hospital for want of an available sub-acute facility.

- The proposed facility will provide a higher skilled nursing home in the area, with greater resources to manage care in the nursing home setting; this will function to reduce readmissions
    - MAHC facilities operate with effective protocols to support effective communications between nursing staff and physicians, and to support symptom management in the nursing home (vs. transfer to the hospital emergency room)
    - MAHC facilities in other markets have demonstrated relatively low readmission rates
- The proposed facility will provide care at a lower cost, and make hospital GBR dollars available for reinvestment in the community. (See response to Question 22.)

(d) Viability of the Proposal

26. The application instructions ask for the following:

> 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.
>
> Given the submission of a letter from the Hertzbach firm rather than audited financial statements, should MHCC assume that such statements are not available? If so, why? If not, please provide such.

Each of MAHC's facilities are legally organized and financed separately. Some entities do have audited financial statements (as required by financing sources) and some are reviewed, but we do not have an audited set of statements that consolidates all entities. Given this, we submitted the letter from Hertzbach as they perform all our independent reviews and audits and therefore could best provide the support requested in the application.

(f) Impact on Existing Providers and the Health Care Delivery System

27. The application did not address the impact on *the volume of service provided by…existing health care providers that are likely to experience some impact as a result of this project* . Once again, note that the jurisdiction carries a surplus of beds and an occupancy rate below 88%. Also note the statement on page 46 (*The balance of patients at the proposed facility are expected to shift from existing nursing homes in Maryland to this new facility*.) Please address this issue.

As described throughout these Responses, the proposed facility does not aim to serve the current population of nursing home patients, but is designed explicitly to serve patients who are currently served in the hospital; **the objective is largely due to shift volume from the hospital setting to the post-acute setting** by providing higher skilled post-acute beds (allowing earlier discharge from the hospital), by serving patient populations that very few nursing homes currently care for (e.g. dialysis and ventilator care and bariatric patients), and by providing a lower cost alternative setting for low acuity admissions, thereby substituting lower cost nursing home days for higher cost hospital days. In the near future, patients may be admitted directly from the emergency room or admitted directly from home and thereby avoid hospitalization altogether. Restore Health will function to reduce unnecessary hospital admissions and will reduce readmission rates. Restore Health will have minimal impact on existing nursing homes because its census will be built from the shift of hospital days to the nursing home or by treating patients the traditional nursing home does not treat.

MAHC recognizes that this dynamic may take some time to take full effect, and that the new nursing home may draw some volume from the conventional nursing home market until such time as Restore Health operates at full capacity with its target population. However, the new facility is expected to have minimal, if any, impact on patient volume at existing nursing homes due to the following factors:

- As emphasized in earlier responses, the very large majority of patients will be patients who are not served by existing nursing home providers. This includes patients with more complex or skilled medical requirements, patients with specialized equipment or monitoring requirements, and patients admitted directly from the community without prior hospitalization. Therefore, existing nursing homes are not expected to see an impact on current operations as a function of this volume being served at Restore Health.
- Almost two-thirds of West Baltimore residents over the age of 65 (and similarly, almost two thirds of Baltimore City residents over the age of 65) who utilize nursing homes are

placed at nursing homes outside of Baltimore City. These numbers include the large number of patients requiring dialysis and ventilator care who are discharged to nursing homes in Prince George's County and Anne Arundel County but also include the broader nursing home population. While the opening of this new nursing home may, in fact, have the effect of moving these referrals "closer to home," (i.e. to a local area facility), this should be recognized as a desirable goal, consistent with the Triple Aim and with community health improvement. Restore Health will function to increase access, improve health, and improve the patient experience of care.

Also explain the statement that "*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."* While the applicant has posited that certain segments of its projected population will be new to the sub-acute market, it has also stated that "the balance" will shift from existing providers. Please define the proportion that will be new to sub-acute care vs. the proportion that will be shifted as part of your impact analysis.

Based on more recent analysis by Berkeley Research Group ("BRG"), MAHC has determined that its volume target can be met by shifts in hospital volume, and the patient volume projected for the facility *will not be drawn from existing nursing home providers*, but drawn from area hospitals. One exception to this is the referral of patients with dialysis and ventilator care requirements, who are now referred to distant out-of-area facilities in Prince George's County and Anne Arundel County. At this time, estimates can only be made from the verbal reports of UMMC and UMMC Midtown; BRG did not have data available from other area hospitals. Reports from these two hospitals – expected to be the major referral sources to the new facility – estimate that more than 150 total dialysis/ventilator or dialysis/tracheotomy patients were placed at out of area facilities in the past year. The very large majority of these patients would be expected to be referred to the new facility, where patients can be closer to local friends and family members. We note that the proposed facility is very accessible by public transportation, which is not the case for distant facilities.

The other exception is the estimated 5% of discharges outside the city, which will be spread among many facilities with a minimal impact on any one. There will be no impact on Baltimore City facilities, since these facilities do not treat these patients now.

28. According to the applicant "The state of Maryland continues to struggle with lowering its overall readmission rate" which was represented as "16.94%, close to 8% higher than the national average" (p.55). Elsewhere in the application (p.42), it is claimed that "a study prepared

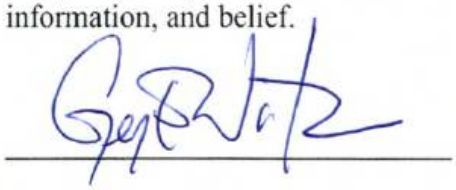
by the Office of Inspector General…cites a 25% national admission rate for nursing home patients, and a Maryland-specific rate of 25.3%" Please explain the variety of numbers.

The overall readmission rate at Maryland hospitals represents to one of the core performance measures which Maryland is required to meet as part of the Demonstration Model and terms of the waiver. The figure cited in the CON application - - a 16.94% readmission rate --represents Maryland's 30-day readmission rate for Medicare patients only; CMS compares this performance measure to the nation's 30-day readmission rate for Medicare patients. Maryland's CY2014 readmission rate of 16.94% was 8% higher relative to the nation's CY2014 Medicare only readmission rate of 15.73% (source: HSCRC's Final Recommendation for Updating the Hospital Readmission Reduction Incentive Program for RY2017, presented March 2015)

In contrast, the report issued by the Office of the Inspector General ("OIG") cites a 25% national admission rate for nursing home patients, and a Maryland-specific rate of 25.3%. This figure is a very different metric as compared with the overall readmission rate for all Medicare *hospital* patients cited above. The figures calculated by the OIG represent the readmission rate to the hospital for nursing home patients, only, and is not limited to a 30-day window. Not surprisingly, this admission rate is higher than the 30-day readmission rate for all Medicare patients discharged from Maryland hospitals, given the health status and fragility of the nursing home patient population and the broader time period examined. (Note, as well, that the OIG figures reflect 2011 data.)

AFFIRMATION

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



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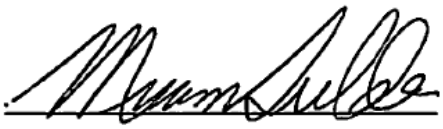

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Michael J. Watson

TABLE OF EXHIBITS

EXHIBIT	DESCRIPTION
Exhibit A	Agreement of Purchase and Sale dated February 13, 2015
Exhibit B	MAHC 30-Day Readmission Rate All Cause, All Payers CY 2014
Exhibit C	Page 141 from the ICPC Quarterly Scorecard, January 1, 2009 to December 31, 2012, Maryland, published by Delmarva Foundation, QIO (June 1, 2013)
Exhibit D	Updated Table C: Revised Project Budget reflecting "cost of other areas" data
Exhibit E	New Revenue and Expense Statement for CY2021
Exhibit F	New copies of former Exhibits H and I
Exhibit G	Letter dated September 19, 2013 demonstrating that the Delmar Nursing and Rehabilitation Center had regained substantial compliance with Federal participation requirements as of September 18, 2013
Exhibit H	Letter dated December 15, 2014 demonstrating that Villa Rosa Nursing And Rehabilitation, LLC had regained substantial compliance with Medicare requirements as of December 10, 2014
Exhibit I	Course description for "Age Specific Care" – part of the Health and Safety Compliance Training Curriculum
Exhibit J	"Envisioning your future in a nursing home" by Margaret P. Calkins, Ph.D. (Article discussing the psychological and clinical advantages to private rooms)
Exhibit K	"Household Models for Nursing Home Environments" by Gaius G. Nelson, SMArchS, NCARB ("Neighborhood Model" discussion)
Exhibit L	Letter of support from the University of Maryland Medical Center Midtown Campus (UMMC Midtown)
Exhibit M	Article by Matthew Amodeo, *CMS Raises Stakes with "Next Generation" ACO* (DrinkerBiddle)
Exhibit N	CMS Next Generation ACO Model – Model Overview Presentation, March 17, 2015 (Slides)
Exhibit O	CMS Next Generation ACO Model – Open Door Forum: Financial Deep Dive, March 31, 2015
Exhibit P	Demand Assessment for Restore Health: Reasonableness Test for Projected Volume (prepared by Berkeley Research Group)
Exhibit Q	PQI Discharges at Baltimore City Hospitals (FY 2014)

AGREEMENT OF PURCHASE AND SALE

THIS AGREEMENT OF PURCHASE AND SALE (this "**Agreement**") is made as of the 13th day of February, 2015 (the "**Effective Date**"), by Baltimore Nursing and Rehabilitation Realty, LLC, a Maryland limited liability company (the "**Purchaser**") and Blue Ocean 300, LLC, a Maryland limited liability company (the "**Seller**").

RECITALS

A. Seller is the owner in fee simple of certain property consisting of (i) the parcels of land located in Baltimore City, Maryland and identified on Exhibit A attached hereto, including, without limitation, all easements, covenants and other rights appurtenant to such land and any land lying in the bed of any street, road, avenue or alley adjoining such land (the "**Real Property**"); (ii) all buildings, structures, garages and any other improvements situated on such land (the "**Improvements**") and all rights, permits and agreements associated with such Improvements, including those pertaining to the use of "air rights," "bridge," or a "tunnel" pursuant to the Baltimore City Ordinances in effect as of the date of this Agreement (the "Franchise Rights"), except as set forth to the contrary in this Agreement; (iii) all systems, equipment, machinery, facilities and fixtures servicing or used solely in connection with the Improvements and all Seller owned appliances, furniture, and other personal property located on or exclusively serving such buildings and other improvements, and all drawings, plans, specifications, and reports in Seller's possession related thereto (the "**Personal Property**"); (iv) all assignable licenses, approvals and permits issued to Seller with respect to any of the foregoing property (the "**Permits**"); (v) all assignable warranties and guaranties regarding any of the foregoing property, if any (the "**Warranties**"); and (vi) all of the rights, title and interest in and to that certain lease between Seller and Scrubs and Beyond, LLC t/a Uniform City, dated December 12, 2013 (the "**Lease**") attached hereto as Exhibit B (the "**Rent Roll**"). The foregoing Real Property, Improvements, Personal Property, Permits, Warranties and Lease are collectively referred to herein as the "**Property**."

B. Seller has agreed to sell the Property to Purchaser, and Purchaser has agreed to purchase the Property from Seller, under all of the terms set forth herein.

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

1. Incorporation of Recitals. The foregoing Recitals are hereby incorporated herein by reference as a substantive part of this Agreement.

2. Purchase and Sale of the Property. Subject to the terms and conditions set forth in this Agreement, Seller agrees to sell to Purchaser, and Purchaser agrees to purchase from Seller, the Property in accordance with the terms of this Agreement.

3. Purchase Price; Terms of Payment; Duties of Escrow Agent.

3.1 Purchase Price. The aggregate purchase price for the Property ("**Purchase Price**") shall be Three Million Dollars ($3,000,000), subject to adjustments and prorations as set forth below and in Section 5. .

3.2 Terms of Payment. The Purchase Price shall be paid by Purchaser as follows:

3.2.1 The Purchaser agrees to pay a deposit of Sixty Thousand Dollars ($60,000) (the "**Initial Deposit**") to the Seller as follows: (a) Twenty Thousand Dollars ($20,000) to be paid on the Effective Date; (b) Twenty Thousand Dollars ($20,000) to be paid on or before thirty-one (31) days after the Effective Date; and (c) Twenty Thousand Dollars ($20,000) to be paid on or before sixty-one (61) days after the Effective Date.

3.2.2 Each installment of the Initial Deposit paid to the Seller shall be non-refundable to the Purchaser. In the event that this Agreement is terminated pursuant to Section 6.1 hereof, then Purchaser shall have no further obligation to pay any installment of the Initial Deposit not yet due and payable. In the event that Purchaser fails to pay any installment of the Initial Deposit within three (3) days of when due, then this Agreement shall be deemed to be terminated and null and void and of no effect. The Initial Deposit will be applied to the Purchase Price in accordance with the terms of this Agreement.

3.2.3 On the first to occur of (a) ninety-one (91) calendar days after the Effective Date or (b) the expiration of the Feasibility Period, Purchaser shall deposit with Continental Title Group in care of Cailin Quinn (the "**Escrow Agent**") the sum of One Hundred and Twenty Thousand Dollars ($120,000.00) (the "**Second Deposit**" and together with the Initial Deposit, collectively the "**Deposit**"). The Deposit shall be non-refundable to Purchaser, and upon receipt, Escrow Agent shall release to Seller Thirteen Thousand Three Hundred and Thirty-Three Dollars ($13,333.00).

3.2.4 Every thirty (30) calendar days from the date of the Second Deposit until the Closing Date, Escrow Agent shall release to Seller the sum of Thirteen Thousand Three Hundred and Thirty-Three Dollars ($13,333.00).

3.2.5 On the Closing Date, the remainder of the Purchase Price, beyond the Deposit, subject to closing adjustments and prorations provided herein, shall be paid by wire transfer of funds to the Escrow Agent for disbursement at closing in accordance with the settlement statement.

3.3 Duties of Escrow Agent. The Escrow Agent agrees to hold and release all sums constituting the Deposit if and when made, as escrowee, in strict compliance with the provisions of this Agreement and in a federally-insured money market or other interest-bearing account reasonably acceptable to Purchaser. It is expressly acknowledged by Seller and Purchaser that the Escrow Agent shall be obligated to escrow the Deposit with a federally-insured institution as aforesaid, but each of Seller and Purchaser recognizes and agrees that the limits of such insurance may be less than the total amount of the Deposit and that the Escrow

Agent shall not be required to spread the Deposit among different institutions in order to fall within the federal insurance coverage limitations. The Escrow Agent acts hereunder as a depository only and is not responsible or liable in any manner whatsoever for the (i) sufficiency, correctness, genuineness or validity of any written instrument, notice or evidence of a party's receipt of any instruction or notice which is received by the Escrow Agent, or (ii) identity or authority of any person executing such instruction, notice or evidence. The Escrow Agent shall have no responsibility hereunder except for the performance by it in good faith of the acts to be performed by it hereunder, and the Escrow Agent shall have no liability except for its own breach of this Agreement, willful misconduct or negligence. The Escrow Agent shall not be responsible for the solvency or financial stability of any financial institution with which Escrow Agent is directed to invest funds escrowed hereunder. The Escrow Agent shall be reimbursed on an equal basis by Purchaser and Seller for any reasonable expenses incurred by the Escrow Agent arising from a dispute with respect to the amount held in escrow, including the cost of any reasonable legal expenses and court costs incurred by the Escrow Agent, should the Escrow Agent deem it necessary to retain an attorney with respect to the disposition of the amount held in escrow. In the event of a dispute between the parties hereto with respect to the disposition of the amount held in escrow, the Escrow Agent shall be entitled, at its own discretion, to deliver such amount to an appropriate court of law pending resolution of the dispute.

4. Closing. The closing of the purchase and sale of the Property shall be held at the offices of the Escrow Agent at 11:00 a.m. on the date which is not more than one (1) year after the Effective Date (hereinafter referred to as the "**Closing Date**"). Purchaser may postpone the Closing Date for one period of thirty (30) days upon (a) providing Seller with written notice thereof not less than thirty (30) days prior to the Closing Date, and (b) releasing to Seller simultaneously with the notice an additional non-refundable deposit of Fifteen Thousand Dollars ($15,000.00). In the event that Purchaser, after diligent efforts, has not obtained the required approval from MHCC for the Certificate of Need transfer by the Closing Date, as extended, then Purchaser shall have an additional right to postpone the Closing Date for two (2) consecutive thirty (30) day increments upon (a) providing Seller with written notice thereof not less than ten (10) days prior to the then-scheduled Closing Date, and (b) paying Seller simultaneously with the respective notice an additional non-refundable fee of Twenty Thousand Dollars ($20,000) for each thirty (30) day extension, which non-refundable fee will not be deemed part of the Deposit and will not be credited to the Purchase Price at Closing and shall be in addition to the Purchase Price. If so postponed, the postponed date shall thereafter be deemed to be the Closing Date.

4.1 Seller's Closing Deliverables. At the closing, Seller shall deliver the following documents (collectively the "**Closing Documents**") and take such actions described below:

4.1.1 a special warranty deed to the Real Property including a covenant of further assurances, duly executed and acknowledged by Seller and in proper form for recording, conveying fee simple title to the Real Property to Purchaser or its designee subject only to the Permitted Exceptions.

4.1.2 an Assignment of Leases in the form attached hereto as Exhibit D (the "**Assignment of Leases**"), together with the Lease and any amendments thereto;

4.1.3 an updated Rent Roll, certified by Seller as true, correct and complete as of the Closing Date;

4.1.4 a Bill of Sale for all of the Personal Property, duly executed and acknowledged by Seller in the form attached hereto as Exhibit E;

4.1.5 an assignment of the Permits and Warranties, duly executed and acknowledged by Seller, assigning to Purchaser all of Seller's right, title and interest in and to all of the Permits and Warranties in the form attached hereto as Exhibit F;

4.1.6 originals, if in Seller's possession, or copies of all certificates of occupancy, licenses, permits, authorizations, consents and approvals required by law and issued by any governmental or quasi-governmental authority having jurisdiction over the Property and copies of all certificates, if any, issued by the local board of fire underwriters (or other body exercising similar functions), in Seller's possession;

4.1.7 a complete set of original as-built architectural and engineering drawings, utilities layout plans, topographical plans, surveys and the like used in the construction, improvement, alteration or repair of the Property to the extent that such items are in Seller's possession;

4.1.8 a certificate updating the representations and warranties made pursuant to Section 7;

4.1.9 a FIRPTA affidavit;

4.1.10 any transfer tax statements, declarations, filings and other similar documents that may be necessary, to the extent the same are reasonably required to be executed by Seller;

4.1.11 a closing statement conforming to the proration and other relevant provisions of this Agreement;

4.1.12 clearly labeled keys to all locks on the Property, to the extent in Seller's possession;

4.1.13 as prepared by Purchaser, a notice to the tenant under the Lease providing the tenant with Purchaser's new mailing address and such other information as Purchaser may reasonably request;

4.1.14 an owner's affidavit of title, idemnities, and such other documents as reasonably required by the Escrow Agent for the Escrow Agent to issue to Purchaser its title insurance policy, all in form and substance reasonably acceptable to the Escrow Agent; and

4.1.15 such other information as the Escrow Agent may reasonably require to demonstrate Seller's due authorization and performance of this Agreement and the foregoing documents.

4.2 Purchaser's Closing Deliverables. At the closing, Purchaser shall deliver the following:

4.2.1 the balance of the Purchase Price as adjusted pursuant to the terms hereof;

4.2.2 the Assignment of Leases; and

4.2.3 a closing statement conforming to the proration and other relevant provisions of this Agreement.

5. Closing Adjustments/Costs.

5.1 Expense Adjustments. The following items of expense shall be adjusted as of 11:59 p.m., of the day immediately preceding the Closing Date such that Seller shall be responsible for all days prior to the Closing Date and Purchaser shall be responsible for the Closing Date and all days thereafter:

5.1.1 Taxes. Real estate, personal property, ad valorem taxes, assessments payable in installments and front foot benefit charges payable in installments that are due and payable with respect to Seller and the Property, respectively, on the basis of the most current bills or other current information available. Assessments payable in a lump sum and not in monthly installments, including any Franchise Taxes set forth in Section 6.3 below, shall be apportioned as of the Closing Date, and Seller shall be responsible for the amounts accrued up to the Closing Date, and Purchaser shall be responsible for the amounts accruing from the Closing Date forward, if any.

5.1.2 Utilities. Fuel, water and sewer service charges, and charges for gas, electricity, telephone and all other public utilities. If there are meters on the Property measuring the consumption of water, gas or electric current, Seller shall cause such meters (for utilities for which Seller, and not tenants, are responsible) to be read not more than one (1) day prior to the Closing Date, and shall pay promptly all utility bills for which Seller is liable upon receipt of a statement therefor. Purchaser shall be liable for and shall pay all utility bills for services rendered after such meter readings. To the extent that meters are not read one (1) day prior to the Closing Date, then the parties shall estimate the amount of such utilities to be adjusted at the Closing based upon prior utility usage, and following the Closing, such adjustments shall be subject to verification in accordance with Section 5.2 hereof.

5.1.3 Rent.

(A) Rent received on or prior to the Closing. The monthly rent and other tenant charges payable by the tenant under the Lease and actually collected by Seller prior to the Closing Date shall be adjusted as of 11:59 p.m. of the day immediately preceding the Closing Date (such that Seller is entitled to retain all amounts allocable to the period prior to the Closing Date and Purchaser is entitled to receive/retain all amounts allocable to the Closing Date and the period from and after the Closing Date). In addition, any rent and other charges prepaid to Seller for the period from and after the Closing Date (including, a pro rata portion of the rent

paid to and received by Seller for the month in which the closing occurs) shall be paid to Purchaser at closing.

(B) Security Deposits. The full amount of all tenant security deposits referenced in the Lease including security deposits for tenants who owe rent or other charges on the Closing Date, together with all interest required to be paid thereon which has accrued through the Closing Date shall be credited to Purchaser on the Closing Date.

(C) Rental Arrearages. Rent and other charges which are due but uncollected as of the Closing Date shall not be adjusted. From and after the Closing Date, Seller shall not have any right to initiate or continue (and shall cease) any collection efforts and/or legal proceedings against any tenants.

(D) Rent Collected After the Closing Date. That portion of any past due rentals collected after the Closing Date which are allocable to the period prior to the Closing Date shall be remitted to the Seller by the Purchaser as and if collected by Purchaser. Payments received by the Purchaser shall be applied first to the then current rent due and then to past rent starting with the most recent delinquency. The Purchaser shall use commercially reasonable efforts to collect past due rents.

5.2 Final Reconciliation. The adjustments described in this Section 5 shall be paid on the Closing Date. If the amount of any of the adjustments described in this Section 5 cannot be determined on the Closing Date, other than 5.1.3 (D), the adjustment therefor shall be made within thirty (30) days after the Closing Date by cashier's check. In making the adjustments required by this subsection, Seller shall be given credit for all amounts prepaid for the Closing Date and any period thereafter, and Seller shall be charged with any unpaid charges accrued during the period prior to the Closing Date.

5.3 Closing Costs. Purchaser shall pay all expenses of examination of title, title insurance commitment and title premiums. All state, county, city, local, and municipal transfer and recordation taxes, if any, owing with respect to the sale of the Property, if any, shall be paid one-half (½) by Seller and one-half (½) by Purchaser. Each of Purchaser and Seller shall pay their own attorneys' fees and expenses incurred in connection with the negotiation of this Agreement and the closing of the transactions contemplated hereby.

6. Due Diligence.

6.1 Feasibility Period/Right to Terminate. Within two (2) days of the execution of this Agreement, Seller shall deliver to Purchaser each of the documents and other information listed on Exhibit C attached hereto or otherwise indicated in writing to Purchaser that such information is not available ("**Due Diligence Documents**"). For the period beginning on the Effective Date and continuing through 5:00 pm on the date that is ninety (90) days from the Effective Date ("**Feasibility Period**"), Purchaser shall have the right, at its sole cost and expense, to conduct such inspections, tests, studies and reviews of the Property as it so determines in its' discretion, including, but not limited to, those pertaining to the physical and environmental conditions of the Property, a comprehensive study of all improvements thereon, inspection, evaluation and testing of the roofs, heating, ventilation and air-conditioning systems

and all components thereof, all files and records of Seller pertaining to the Property and the occupancy, maintenance, operation and repair thereof and to inspect, upon reasonable notice to, consent of and in the company of Seller, the interior of each leased premises and to review such other information it may reasonably desire concerning the Property (collectively, the "**Inspections**"), which shall be subject to Section 6.4 below. If Purchaser is not satisfied, in its sole and absolute discretion, with the results of Purchaser's Inspections of the Property or otherwise elects not to proceed to closing for any reason or no reason, Purchaser may terminate this Agreement by giving written notice thereof to Seller, which notice must be delivered in accordance with the terms hereof to Seller on or before 5:00 p.m. of the last day of the Feasibility Period. If Purchaser terminates this Agreement as aforesaid, the Escrow Agent shall promptly deliver the balance of the Deposit held to Seller, and Purchaser shall promptly deliver to Seller all Due Diligence Documents, whether originally received from Seller or copies of those obtained by Purchaser in connection with the Inspection. From and after Purchaser's timely termination of this Agreement as aforesaid, neither Seller nor Purchaser shall have any further rights or liabilities hereunder (except for such rights and liabilities as expressly survive the termination of this Agreement).

6.2 Environmental Investigation. During the Feasibility Period as part of Purchaser's Inspections of the Property, Purchaser and its agents shall have the right to conduct a "Phase I" environmental assessment of the Property, and upon Seller's prior written consent, any follow-up on inspections/assessments as reasonably determined by Purchaser after review of such Phase I. In furtherance of Section 6.5 below, Purchaser shall rely solely on the results of the reports obtained hereunder in connection with the Property's environmental condition. Any environmental investigation shall be subject to the terms of Section 6.4 hereof.

6.3 Title. During the Feasibility Period and as part of Purchaser's Inspections of the Property, Purchaser shall have the right to inspect the status of title to the Property. Promptly after the Effective Date, Purchaser may obtain a title report or title commitment ("**Commitment**") and, at Purchaser's election, a survey and bankruptcy, judgment and lien searches with respect to Seller and/or the Property. In the event the Commitment and/or other report or searches disclose or Purchaser becomes aware of any lien on the Property created by Seller that can be discharged or satisfied by the payment of money ("**Monetary Title Matters**"), Seller shall discharge or satisfy such Monetary Title Matters on or prior to the Closing Date. If Seller fails to discharge or satisfy any such Monetary Title Matters as aforesaid, Purchaser, at its sole option, and in addition to any other rights and remedies it may have under this Agreement, at law and/or in equity, shall have the right to terminate this Agreement and/or discharge and satisfy (or cause the Escrow Agent to discharge and satisfy) the same from the proceeds of the Purchase Price to be paid to Seller at Closing. Title to the Property shall be subject only to the following matters: (i) the lien of real estate taxes, assessments and sewer and water rents not yet due and payable; (ii) such matters appearing on the Commitment or survey to which Purchaser shall fail to object or shall be deemed to accept during the Feasibility Period; (iii) the Leases, (iv) any title exception created by any act or omission of the Purchaser or its representatives, agents, employees or invitees, and (v) the assessment of Franchise Taxes defined hereinafter (collectively, the "**Permitted Exceptions**").

Seller, through outside counsel, is and continues to move towards (i) acquiring the air rights and terminating the City's franchise associated with the Property and bridge attached

thereto extending over Marion Street, and (ii) abandon the tunnels and terminate the City's franchise associated with the Property and tunnels thought to exist under Marion Street (collectively, the "**Franchise Taxes**", and collectively, these efforts and actions shall be referred to as the "**Franchise Efforts**"). Any reduction or termination in the Franchise Taxes shall inure to the benefit of Purchaser after the Closing Date. The parties, however, agree that in consideration for the costs and fees incurred by Seller in connection with the Franchise Efforts, any settlement between the Seller and the City or any other property owner, whether reached before or after the Closing Date, shall go directly and solely to Seller. The terms of the reduction and/or termination of the Franchise Taxes shall be subject to the approval of the Purchaser, such approval not to be unreasonably withheld, conditioned or delayed. The terms of this Section in connection with the Franchise Efforts shall survive the Closing Date.

Title to the Property shall be insurable at regular rates from a title insurance company licensed in the State of Maryland and selected by Purchaser. In the event Purchaser's review of title to the Property reveals any matters that are unacceptable to Purchaser in its sole and absolute discretion (other than Monetary Title Matters Seller is required to remedy as aforesaid), Purchaser shall notify Seller thereof within sixty (60) days after the Effective Date (the "**Objection Notice**"). Within ten (10) days after receipt of the Objection Notice, Seller shall notify Purchaser in writing, whether Seller shall undertake to cure such unacceptable exception(s). In the event Seller elects not to cure any unacceptable exception, then Seller shall within such ten (10) day period, provide written notice of its intent to leave such matter uncured. Purchaser shall have until the end of the Feasibility period to advise Seller in writing whether Purchase shall, (a) accept title subject to the objections raised by Purchaser, without an adjustment of the Purchase Price, in which event each of said objections shall be deemed waived for all purposes and considered a Permitted Exception, or (b) terminate this Agreement. If Purchaser shall terminate this Agreement, then (i) this Agreement shall be deemed to have terminated as of the date of Purchaser's notice without need for any further action by either party, (ii) neither Purchaser nor Seller shall have any further obligations to one another hereunder, except for those which expressly survive termination of this Agreement.

6.4 Conditions of Conducting Due Diligence. Purchaser's right to conduct due diligence on, at or otherwise with respect to the Property during the Feasibility Period shall be subject to Purchaser's continuing compliance with each and all of the following conditions: (i) Seller shall permit Purchaser, and its agents, representatives and contractors, to have reasonable access to the Property, upon reasonable notice to Seller and Seller's prior consent, not to be unreasonably withheld, conditioned or delayed, and subject to the rights of tenants of the Property; (ii) all such due diligence shall be conducted so as not to cause any unreasonable or material disruption to the operation of the Property or tenants under the Lease; (iii) Purchaser shall at all times comply with all laws, ordinances, rules and regulations applicable to the Property; (iv) promptly after entry onto the Property, Purchaser shall restore or repair (to substantially the same condition it existed prior to the entry) any damage thereto caused by or otherwise arising from any act or omission by Purchaser, its agents, representatives or contractors; and (v) prior to conducting any Inspection of the Property, Purchaser shall furnish to Seller satisfactory evidence that Purchaser and its agents and contractors have procured comprehensive liability insurance from an insurer authorized to do business in the State of Maryland which is reasonably acceptable to Seller protecting Seller from claims for property damage, bodily injury or death in single limit amount of not less than $1,000,000.00, naming

Seller as an additional insured. Notwithstanding the foregoing, (i) Purchaser shall not conduct (or arrange for the conduct of) any invasive testing on the Property without Seller's prior written consent; and (ii) Purchaser shall schedule all invasive testing with Seller, and Seller shall have the right to be present for such testing. Purchaser shall indemnify, defend, reimburse, and hold and save Seller harmless from and against any and all reasonable and actual loss, cost, damage, injury or expense arising out of or in any way related to claims by third parties for damage to personal property or bodily injury solely as a result of the acts or omissions of Purchaser, its agents, employees and contractors, relating to any such entry. The indemnification provision contained in this Section shall survive the closing or early termination of this Agreement. Purchaser's right to continue to conduct due diligence on, at or otherwise with respect to the Property prior to the Closing Date shall be subject to Purchaser's continuing compliance with each and all of the conditions set forth above in addition to Section 9.1 below.

6.5. No Reliance on Documents; As-Is Sale.

(a) The Due Diligence Documents are accurate and complete to the best of Seller's knowledge.

(b) Except as expressly set forth in this Agreement, it is understood and agreed that the Seller is not making and the Seller has not at any time made, any warranties or representations of any kind or character, express or implied, with respect to the Property, including, but not limited to, any warranties or representations as to habitability, merchantability or fitness for a particular purpose, or as to the state of title, physical condition, environmental condition and/or zoning of the Property.

(c) THE PURCHASER ACKNOWLEDGES AND AGREES THAT UPON CLOSING THE SELLER SHALL SELL AND CONVEY OR ASSIGN TO THE PURCHASER AND THE PURCHASER SHALL ACCEPT THE PROPERTY "AS IS, WHERE IS, WITH ALL FAULTS" AND WITH ALL LATENT OR PATENT DEFECTS. THE PURCHASER HAS NOT RELIED AND WILL NOT RELY ON, AND THE SELLER IS NOT LIABLE FOR OR BOUND BY, ANY EXPRESS OR IMPLIED WARRANTIES, GUARANTIES, STATEMENTS, REPRESENTATIONS OR INFORMATION PERTAINING TO THE PROPERTY OR RELATING THERETO MADE OR FURNISHED BY THE SELLER NOR ANY AFFILIATE, AGENT OR ATTORNEY OF THE SELLER, TO WHOMEVER MADE OR GIVEN, DIRECTLY OR INDIRECTLY, ORALLY OR IN WRITING.

(d) Except as to provisions of this Agreement which explicitly survive Closing, the Purchaser's acceptance of the Deed shall be deemed to be full performance by the Seller of, and will discharge the Seller from, all liabilities and obligations under this Agreement, and thereafter the neither the Seller nor any of its affiliates shall have any liability or obligation to the Purchaser, nor any liability or obligation to any subsequent owner of the Property with respect to the Property, nor any liability or obligation to any other person, firm, corporation, or public body with respect to the Property.

(e) The provisions of this Section 6.5 shall survive Closing or termination of this Agreement.

7. Representations and Warranties of Seller. Notwithstanding Section 6.5 above, Seller hereby makes the following representations and warranties to Purchaser, all of which are made as of the Effective Date and shall be true and correct in all material respects on and as of the Closing Date. Except for the explicit representations and warranties made in this Section 7, the Property is being sold in its "as-is" condition, without representation or warranty.

7.1 Enforceability; Authorization. This Agreement and the documents, affidavits, certificates and other instruments to be executed and delivered by Seller pursuant hereto are, or will be when executed and delivered by Seller, the legal, valid and binding obligations of Seller and enforceable against Seller in accordance with its terms.

7.2 No Conflicts. Neither the execution of this Agreement nor the consummation of the transactions contemplated hereby will conflict with, or result in a breach of, the terms, conditions or provisions of, or constitute a default under, any agreement or instrument to which Seller is a party, including but not limited to, any agreement pertaining to the Franchise Taxes, Franchise Efforts and/or "air rights," "tunnels," or "bridges," at or adjacent to the Property (collectively "**Franchise Matters**").

7.3 Third Party Consents. To Seller's knowledge, all consents required from any governmental authority or third party in connection with the execution and delivery of this Agreement by Seller or the consummation by Seller of the transactions contemplated hereby, including the transfer of any rights associated with the Franchise Matters, have been made or obtained or shall have been made or obtained by the Closing Date.

7.4 Lease. Attached hereto as Exhibit B is a true and complete copy of the Lease and the Rent Roll, including (i) the name of the tenant, (ii) the date of the Lease (iii) all rental delinquencies existing under the Lease as of the close of the month immediately preceding the date of this Agreement, and (iv) the amount of security deposits required to be held pursuant to such Lease. The Lease identified on Exhibit B is the only lease or grants of occupancy with respect to all or any part of the Property.

7.5 Contracts. Except for the Lease identified on Exhibit B, there are no maintenance, repair, janitorial, garbage hauling, laundry, snow removal, cleaning, supplier, management, leasing or other contracts or agreements affecting or relating to the Property except as detailed on Exhibit G attached hereto (the "**Contracts**"). To its knowledge, Seller is not in default under any of the Contracts. Unless set forth in the Contracts, all Contracts may be terminated by Seller without fee or penalty upon notice of thirty (30) days or less. Unless Purchaser elects in writing prior to the Closing Date, all Contracts will be terminated as of the Closing Date to the extent they are terminable.

7.6 Other Agreements. Seller is not a party to any agreements relating to the Property other than the Lease, the Contracts and the Permitted Exceptions that would survive Closing.

7.7 Violation of Laws, Etc. Seller has not received written notice from any governmental authority, nor does Seller have any knowledge, of any existing violations of any federal, state, county or municipal laws, ordinances, orders, codes, regulations or requirements affecting all or any portion of the Property, including, without limitation, violations of the

housing, building, safety, health, environmental, fire or zoning ordinances, codes and regulations of the jurisdiction within which the Property is located or the certificate(s) of occupancy issued for the Property.

7.8 Hazardous Conditions. Based solely on the reports delivered as a part of the Due Diligence Documents, and the knowledge of Rebecca Armenta, the Property Manager, Seller has no actual knowledge of the generation, storage, or disposal of hazardous substances on the Property. For the purpose of this Agreement, "hazardous substances," shall mean "hazardous substance," "hazardous waste" and "hazardous material" as defined in (i) the Comprehensive Environmental Response, Compensation and Liability Act, as amended, (ii) the Resource Conservation and Recovery Act, as amended, and (iii) any other applicable provisions of Federal or Maryland law, and the regulations adopted pursuant thereto relating to the regulation of environmental matters or other substances deemed hazardous to human health or the environment. "**Environmental Laws**" means any law, statute, ordinance, rule, regulation, guideline or order relating to the items described in clauses (i), (ii) or (iii) in the preceding sentence.

7.9 Litigation. No litigation relating to Seller, the Leases or the Property or any part thereof is pending or, to Seller's knowledge, threatened in any court or other tribunal or before any Governmental Authority. Seller is not the subject of, nor has Seller received any written notice of or threat that it has or will become the subject of, any actions or proceedings under the United States Bankruptcy Code, 11 U.S.C. §§ 101, et seq. ("**Bankruptcy Code**"), or under any other federal, state or local laws affecting the rights of debtors and/or creditors generally, whether voluntary or involuntary and including, without limitation, proceedings to set aside or avoid any transfer of any interest in property or obligations, whether denominated as a fraudulent conveyance, preferential transfer or otherwise, or to recover the value thereof or to charge, encumber or impose a lien thereon.

7.10 FIRPTA. Seller is not a "foreign person" within the meaning of Section 1445 of the Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder (the "**Code**"), and the sale of the Property is not subject to the federal income tax withholding requirements of such section of the Code.

7.11 Tax Matters. No federal or other taxing authority (each, a "**Taxing Authority**" and collectively, the "**Taxing Authorities**") has asserted in writing any tax deficiency, lien, interest or penalty against Seller or the Property that has not been paid (except as to the Franchise Taxes which shall be resolved or paid by Closing Date), and to Seller's knowledge, there is no pending audit or inquiry from any Taxing Authority relating to Seller or the Property.

7.12 Re-Zoning. Seller is not a party to, nor does Seller have any actual knowledge of, any threatened proceeding for the rezoning of the Property or any portion thereof.

7.13 Condemnation. Seller has not received any written notice advising it of any pending or threatened condemnation or other governmental taking proceedings affecting all or any part of the Property.

8. Representations and Warranties of Purchaser. Purchaser hereby represents and warrants to Seller that: (i) Purchaser is a Maryland limited liability company and is in good standing in the State of Maryland; (ii) this Agreement and the documents, affidavits, certificates and other instruments to be executed and delivered by Purchaser pursuant hereto are, or will be when executed and delivered by Purchaser, legally binding on, and enforceable against, Purchaser in accordance with their respective terms except as the same may be limited by applicable bankruptcy, insolvency, reorganization, receivership and other similar laws affecting the rights and remedies of creditors generally and by general principles of equity (whether applied by a court of law or equity); and (iii) neither the execution of this Agreement nor the consummation of the transactions contemplated hereby will conflict with, or result in a breach of, the terms, conditions or provisions of, or constitute a default under, any agreement or instrument to which Purchaser is a party.

9. Seller Covenants.

9.1 Inspection. Seller shall make available to Purchaser during normal business hours during the Feasibility Period all information reasonably requested by Purchaser in Seller's or its management agent's possession concerning the Property, including, without limitation, all books and records and plans and specifications. Provided that this Agreement is not terminated during the Feasibility Period, Seller shall continue to cooperate with Purchaser upon prior written request for reasonable access to the Property and books and records in Seller's possession, and Purchaser acknowledges that any inspection or study conducted after the Feasibility Period is for the Purchaser's convenience and education only and any and all rights to terminate the Agreement under Section 6.1 have expired or were waived by Purchaser.

9.2 Operation and Maintenance. Seller agrees that from the date of this Agreement to the Closing Date, Seller will, at its sole cost and expense: (i) operate the Property in a commercially reasonable manner; (ii) maintain the Property in substantially the same condition and otherwise continue its usual maintenance program for the Property, through the Closing Date; (iii) comply with and perform all material provisions and obligations to be complied with and/or performed by Seller under the Lease and Contracts (if any); and (iv) maintain in full force and effect its current all-risk casualty insurance policy for the Property and all improvements thereon. Seller further agrees that from the Effective Date until the Closing Date, it will cease all leasing efforts at the Property and shall not enter into any lease or other agreement for occupancy of all or a portion of the Property without Purchaser's prior written consent, which may be withheld in its sole and absolute discretion.

9.3 Contracts. Seller shall not enter into any new contracts, nor shall it modify any Contracts, except to fulfill its express obligations hereunder.

9.4 Leases. Seller shall not enter into any new Leases or renewals, extensions or modifications of Leases (collectively, "**Modifications**") or cancel or terminate or accept surrender of any Leases, apply any security deposits or consent to the assignment, subletting or mortgaging of any Lease (collectively, "**Lease Actions**") after the end of the Feasibility Period without first obtaining the express written consent of Purchaser, which consent shall not be unreasonably withheld, conditioned or delayed.

9.5 Title and Encumbrances. Seller hereby agrees that, after the Effective Date, it shall not take any action affecting title to the Property (except for actions effectuating the release of liens or encumbrances in accordance with the terms of this Agreement) unless consented to by Purchaser, which consent may be withheld in Purchaser's sole and absolute discretion. In all events, Seller will cause to be removed, paid off, released and/or discharged at closing any mortgage, judgment, deed of trust or lien against the Property and any lien affecting title to the Property and arising subsequent to the date of the Commitment referred to above, provided any such lien is not the result of Purchaser's actions upon or in connection with the Property.

9.6 Real Estate Tax Assessments. Prior to the Closing Date and subject to the Franchise Efforts, Seller shall not institute any proceeding or application for a reduction in the real estate tax assessment of the Real Property for any tax year without the prior written consent of Purchaser, which consent may be withheld in Purchaser's sole and absolute discretion.

9.7 Payment of Taxes. Subject to the Franchise Efforts, Seller shall pay all federal, state, county, local and foreign income, excise, real and personal property, sales and other taxes which first become due and payable prior to or on the Closing Date.

9.8 Marketing. At all times prior to closing hereunder, Seller shall not negotiate in any manner for the sale or transfer of the Property with any third party.

9.9 Equipment/Property Warranties. No appliances or articles of personal property belonging to Seller and located on or used solely for the operation of the Property shall be removed from the Property prior to closing, unless replaced by items of like kind and quality, and all such appliances and articles of personal property shall be maintained and repaired by Seller prior to closing, as may be required to keep such items in the same condition as they were on the date of this Agreement.

10. Conditions Precedent to Purchaser's Obligation to Purchase. The obligation of Purchaser to acquire the Property including without limitation the performance of the covenants and obligations to be performed by it on the Closing Date shall be subject to the following conditions precedent (which conditions precedent shall inure solely to the benefit of Purchaser, and no other person or entity, including, without limitation, Seller, shall have any right to waive or defer any of such conditions, in whole or in part):

(i) Subject to Section 12.1, Seller shall have performed in all material respects its covenants and obligations required by this Agreement to be performed or complied with by it on or before the Closing Date.

(ii) Subject to Section 12.1, all of Seller's representations and warranties in this Agreement shall be true and correct in all material respects as of the Closing Date with the same force and effect as though such representations and warranties had been made on and as of such date.

(iii) Delivery of possession of the Property to Purchaser at Closing, which shall be in substantially the same condition it is in on the date of this Agreement, subject to casualty

and/or condemnation and the provisions of this Agreement relating thereto and ordinary wear and tear, subject to the rights of tenants under the Leases.

(iv) Title to the Property on the Closing Date shall be in accordance with Section 6.3 above.

11. Condemnation and Casualty. If, prior to the Closing Date, Seller receives written notice of any pending or threatened condemnation proceedings or actions or if there occurs any material damage, destruction or casualty with respect to all or any portion of the Property, Seller shall promptly notify Purchaser thereof in writing. In the event there occurs: (i) any actual or pending condemnation of any portion of the Property; or (ii) any casualty affecting ten percent (10%) or more of the Property, Purchaser shall have the right to terminate this Agreement by giving notice to Seller within ten (10) days after receipt of Seller's notice advising Purchaser of the occurrence of the casualty or pending condemnation. If: (i) Purchaser fails to notify Seller of Purchaser's election to terminate this Agreement within such 10-day period; or (ii) Purchaser elects to proceed to closing and not terminate this Agreement, then Purchaser shall proceed to closing, without adjustment of the Purchase Price, subject to such condemnation or casualty, in which event at closing, Seller shall, as applicable: (A) assign to Purchaser any condemnation award or rights thereto paid or payable or otherwise accruing to Seller on account of such condemnation; or (B) assign to Purchaser all of Seller's right, title and interest in and to the proceeds of any casualty insurance payable to Seller on account of such casualty and pay to Purchaser an amount equal to any deductible or coinsurance applicable to the casualty insurance under such insurance policies. If Purchaser timely elects to terminate this Agreement as aforesaid, Escrow Agent shall return the Deposit to Purchaser, and neither Purchaser nor Seller shall have any further rights or liability under this Agreement except for such rights and liabilities as expressly survive termination hereof.

12. Breach/Termination.

12.1 Breach by Seller.

If Seller shall fail to perform its material covenants or agreements required to be performed at or before the Closing Date and such failure shall continue for five (5) days after written notice from Purchaser, or if any of Seller's representations and warranties set forth in this Agreement are not true and correct in all material respects on the date hereof or on the Closing Date, Purchaser shall have the right, after providing written notice to Seller and a five (5) day right to cure, to: (i) terminate this Agreement and receive a refund of any such portion of the Deposit which has not yet become non-refundable under the terms of this Agreement, and thereupon neither party shall have any further rights or obligations to the other under this Agreement except such rights and obligations as expressly survive termination of this Agreement; or (ii) pursue specific performance.

12.2 Breach by Purchaser. If Purchaser shall fail to perform any of the covenants or agreements to be performed by it hereunder and such failure shall continue for five (5) days after written notice from Seller (except there shall be no notice requirement for a failure to terminate this Agreement prior to the expiration of the Feasibility Period), or if any of

Purchaser's representations and warranties set forth herein shall not be true and correct in all material respects as of the date made or deemed made or as of the Closing Date, Seller's exclusive remedy shall be to terminate this Agreement, receive the Deposit (Escrow Agent to pay the Deposit to Seller upon Seller's request), as well as an action for any actual damages claimed relating to Purchaser's obligations under Sections 6 and 12.3 hereof as such obligations expressly survive the early termination of this Agreement or the Closing Date.

12.3 Litigation Costs. In the event of any litigation between the parties with respect to this Agreement, including any action for specific performance that may be brought by Purchaser as provided above, the prevailing party shall be entitled to recover reasonable attorney's fees and expenses.

13. Brokers. Each party hereto represents and warrants to the other that it has dealt with no brokers or finders in connection with this transaction other than the representation of the Seller by Transwestern and the Purchaser by Cassidy Turley (collectively, the "**Brokers**"), the commissions of which shall be payable in accordance with a separate agreement between Seller and Brokers. In the event that any claim for commission or finder's fee is brought by any other person or entity as a consequence of the transactions contemplated hereby and as a result of any action or omission of the Seller or Purchaser, then the Seller or the Purchaser, as the case may be, shall indemnify and hold harmless the other party against any loss, cost, or expense of any nature, including but not limited to, Court costs and reasonable attorneys' fees arising as a consequence of the claim for the commission or fee. The terms of this Section 13 shall survive the Closing Date.

14. Entire Agreement/Modification. This Agreement, including the exhibits attached hereto, contain the entire agreement between the parties relating to the conveyance of the Property, all prior negotiations between the parties are merged into this Agreement and there are no promises, agreements, conditions, undertakings, warranties or representations, oral or written, express or implied, between them other than as set forth in this Agreement, including the exhibits attached hereto. No change or modification of this Agreement shall be valid unless the same is in writing and signed by each of the parties hereto or thereto. No waiver of any of the provisions of this Agreement executed or to be executed in connection herewith shall be valid unless in writing and signed by the party against whom it is sought to be enforced. Notwithstanding the foregoing, in the event that Purchaser and Seller agree to and execute any written amendment or other document modifying this Agreement, which does not directly modify the obligations of the Escrow Agent hereunder, the Escrow Agent shall not be required to execute such amendment or other agreement in order for the document to be fully effective and enforceable.

15. Miscellaneous.

15.1 Binding Effect. This Agreement shall be binding upon, and inure to the benefit of and be enforceable by, the respective personal representatives, successors and permitted assigns of the parties hereto.

15.2 Governing Law; Venue. The provisions of this Agreement shall be governed by the laws of the State of Maryland, without regard to the conflicts of laws provisions thereof. Any suit involving any dispute or matter arising under this Agreement may only be

brought in the Circuit Court for Baltimore County, Maryland; provided, that if any such action or proceeding arises under the Constitution, laws or treaties of the United States of America, or if there is a diversity of citizenship between the parties thereto, so that it is to be brought in a United States District Court, it may be brought in the United States District Court for the District of Maryland. All of the parties hereto hereby consent to the exercise of personal jurisdiction by any such court with respect to any such proceeding.

15.3 Notices. Any notice, demand, consent, election, offer, approval, request, or other communication (collectively a "notice") required or permitted under this Agreement must be in writing and delivered (i) personally, or (ii) sent by certified or registered mail, postage prepaid, return receipt requested, or (iii) by a nationally recognized overnight courier, or (iv) by email as set forth below. A notice must be addressed to a party as indicated below. Any notice hereunder shall be deemed duly delivered (x) when delivered, with written receipt, if personally delivered or delivered by nationally recognized overnight courier, or (y) three (3) days after mailing, if mailed by certified mail, return receipt requested, postage prepaid, or (z) when delivered by email if emailed to the addresses listed herein, accompanied by a confirmation of receipt, and followed by overnight delivery by a nationally recognized overnight courier. Any party may designate a change of address by written notice to the other in accordance with the provisions set forth above, which notice shall be given at least ten (10) days before such change of address is to become effective. Seller's notice address: c/o Blue Ocean Realty, LLC, Attn.: Jonathan Ehrenfeld, 6615 Reisterstown Road, 3rd Floor, Baltimore, Maryland 21215, jehrenfeld@blueoceanrealty.net, with a copy to: Erin H. Murphy, 6615 Reisterstown Road, 3rd Floor, Baltimore, MD 21215, emurphy@blueoceanrealty.net; Purchaser's notice address: 1922 Greenspring Drive, Suite 6, Timonium, MD 21093, Attn:: Michael Mahon, MMahon@mid-atlanticltc.com, with a copy to: Paul D. Trinkoff, Miles & Stockbridge, 100 Light Street, Baltimore, MD 21202, ptrinkoff@milesstockbridge.com; Escrow Agent's notice address: Continental Title Group, Attn: Cailin Quinn, 1500 Whetstone Way, Suite T-100, Baltimore, Maryland 21230, cquinn@continentaltg.com.

15.4 Incorporation. Each and all of the exhibits and schedules attached hereto are hereby incorporated into this Agreement by reference.

15.5 Further Assurances. Each of the parties agrees that it will, at any time and from time to time after the Closing Date, upon reasonable request of the other party, do, execute, acknowledge and deliver, or will cause to be done, executed, acknowledged and delivered, all such further acts, deeds, assignments, transfers, conveyances, powers of attorney and assurances as may be reasonably required for the better assigning, transferring, granting, assuring and confirming to the requesting party, or to its successors and assigns (in the case of Purchaser, permitted assigns) of, or for aiding and assisting in collecting and reducing to possession, any or all of the assets or property being transferred pursuant to this Agreement; provided, however, that any instruments to be executed by a party shall be in form and substance reasonably acceptable to such party and in no event shall either party be required to incur any liability or obligation in addition to that which it is obligated to incur under this Agreement. The provisions of this Section shall survive the closing of the transactions contemplated by this Agreement.

15.6 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall

constitute one and the same instrument; provided, however, in no event shall this Agreement be effective unless and until signed by all parties hereto. Fax or email copies of this Agreement shall be sufficient for all purposes.

15.7 Risk of Loss. Risk of loss or damage from fire or other casualty until execution of the deed conveying the Property to Purchaser is assumed by Seller.

15.8 Rules of Construction. Section captions used in this Agreement are for convenience only and shall not affect the construction of the Agreement. All references to "Sections", without reference to a document other than this Agreement are intended to designate articles and sections of this Agreement, and the words "herein," "hereof," "hereunder" and other words of similar import refer to this Agreement as a whole and not to any particular Section, unless specifically designated otherwise. The use of the term "including" shall mean in all cases "including but not limited to," unless specifically designated otherwise. No rules of construction against the drafter of this Agreement shall apply in any interpretation or enforcement of this Agreement, any documents or certificates executed pursuant hereto, or any provisions of any of the foregoing.

15.9 Computation of Time. In computing any period of time pursuant to this Agreement, the day of the act or event from which the designated period of time begins to run will not be included. The last day of the period so computed will be included, unless it is a Saturday, Sunday or legal holiday in Maryland, in which event the period runs until the end of the next day which is not a Saturday, Sunday or such legal holiday.

15.10 Time of the Essence. Time shall be of the essence under this Agreement.

15.11 No Third Party Beneficiaries. None of the rights or obligations provided hereunder shall inure to the benefit of any third party.

15.12 Waiver of Trial by Jury. THE PARTIES HERETO HEREBY AGREE TO WAIVE ANY RIGHTS THEY MIGHT OTHERWISE HAVE TO A TRIAL BY JURY UNDER ANY PROVISION OF ANY APPLICABLE LAW.

[SIGNATURES APPEAR ON NEXT PAGE]

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

WITNESS:

Name: _____

SELLER:

Blue Ocean 300, LLC
a Maryland limited liability company

By: Blue Ocean Realty, LLC
a Maryland limited liability company
Its: Manager

By: _____
Name: Jonathan Ehrenfeld
Its: Manager

WITNESS:

Name: George Watson

PURCHASER:
Baltimore Nursing and Rehabilitation Realty, LLC
a Maryland limited liability company

By: _____
Name: Scott Potter
Title: CFO

JOINDER

Continental Title Group joins herein to evidence its agreement to fulfill any and all obligations of Escrow Agent set forth in this Agreement.

Continental Title Group
a Maryland _____

Name: _____

By: _____
Name: Cailin Quinn
Title: Vice President

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

WITNESS:

Name: [illegible]

SELLER:

Blue Ocean 300, LLC
a Maryland limited liability company

By: Blue Ocean Realty, LLC
a Maryland limited liability company
Its: Manager

By: [signature]
Name: Jonathan Ehrenfeld
Its: Manager

WITNESS:

Name: George Watson

PURCHASER:
Baltimore Nursing and Rehabilitation Realty, LLC
a Maryland limited liability company

By: [signature]
Name: Scott Potter
Title: CFO

JOINDER

Continental Title Group joins herein to evidence its agreement to fulfill any and all obligations of Escrow Agent set forth in this Agreement.

Name: Dana Mitchelman

Continental Title Group
a Maryland

By: [signature]
Name: Cailin Quinn
Title: Vice President

EXHIBIT A

Property Description

EXHIBIT A

Legal Description

Beginning for the same at a point formed by the intersection of the west side of Kimmel Alley (10 feet wide) and the north side of West Fayette Street (66 feet wide); thence binding on the north side of said West Fayette Street

1) South 87 degrees 13 minutes 57 seconds West 89.02 feet; thence leaving said West Fayette Street and binding reversely along the east and north sides (Lines 3A and 4) of Parcel Four described in a Confirmatory Deed dated January 28, 2003 conveyed by Fayette Garage Associates unto Fayette Garage, LLC recorded among the Land Records of Baltimore City in Liber FMC No. 3337, folio 131; the seven following courses and distances:
2) North 02 degrees 36 minutes 08 seconds West 86.37 feet;
3) South 87 degrees 19 minutes 20 seconds West 20.08 feet;
4) North 02 degrees 58 minutes 10 seconds West 1.05 feet;
5) South 87 degrees 32 minutes 03 seconds West 20.22 feet;
6) North 03 degrees 04 minutes 17 seconds West 19.73 feet;
7) North 88 degrees 08 minutes 16 seconds East 3.86 feet; and
8) North 02 degrees 51 minutes 58 seconds West 49.20 feet to the south side of Marion Street (20 feet wide); thence binding on the south side of said Marion Street
9) North 87 degrees 05 minutes 42 seconds West 125.10 feet to an intersection formed by the south side of said Marion Street and the west side of the aforementioned Kimmel Alley; and thence binding on the west side of Kimmel Alley
10) South 02 degrees 59 minutes 28 seconds East 156.73 feet to the place of beginning. Containing 16,514 square feet or 0.3791 of an acre of land, more or less.

The improvements thereon being known as 300 thru 306 West Fayette Street.

EXHIBIT B

Rent Roll

EXHIBIT C
Due Diligence Documents

1. Copies of the Lease and any occupancy agreements and amendments thereto;

2. The most recent survey for the Property in the possession or control of Seller along with any surveyor's reports or certifications, to the extent in Seller's possession, custody or control;

3. Copies of the most recent title policy or commitment for the Property, including copies of all exceptions thereto, to the extent in Seller's possession, custody or control;

4. A true, correct and complete copy of each Contract, including the Agreement for Management of Real Property, in the possession, custody or control of Seller;

5. Copies of three (3) years of real estate tax bills, including special assessments or incentives, copies of all tax protests, related correspondence and protest results, for the Property, including without limitation the Franchise Tax and Franchise Efforts, to the extent in Seller's possession, custody or control;

6. Copies of one (1) year of utility bills for the Property, to the extent in possession of Seller or its property manager;

7. Financial books and records for the Property, including, without limitation, detailed operating statements, current year-to-date and a 12-month rolling history, schedule of replacement costs and capital expenditures (if not already included in detailed operating statements), current year-to-date and a 12-month rolling history and general ledgers and current year-to-date;

8. All documents pertaining to (a) the "Franchise Taxes;" (b) the "Franchise Efforts;" (c) the "Franchise Matters;" (d) the "Franchise Rights," and all rights of Seller or others in and to any "air rights," "bridge," or "tunnel" associated with the Property;

9. All third party engineering and environmental reports and assessments (both draft and final), including any Phase I or II assessments, action and/or work plans, contracts for remediation, incident reports, remediation reports, tank removal and/or closure reports, soil and groundwater sampling reports and results to the extent within Seller's or property manager's possession, in Seller's possession, custody or control;

10. All termite, radon and mold tests or studies to the extent within Seller's or servicing agent's possession, custody or control;

11. A copy of all plans and specifications in the possession or control of Seller relating to the improvements on the Property, and any alterations thereto, including any site plans and as-built drawings;

12. All permits, warranties, certificates of occupancy, and unexpired guaranties and any pending applications for the same;

13. Insurance policies covering the Property;

14. A summary of all pending insurance claims relating to the Property;

15. A schedule of pending litigation affecting the Property;

16. Sellers' title deed;

17. Appraisals in the possession or control of Seller or its' property managers;

18. Property condition reports, including any roofing reports or structural analyzes, in Seller's possession, custody or control;

19. Public works or development agreements and any associated security or bonds, in Seller's possession, custody or control; and

20. Special use permits, variances or special exceptions pertaining to the Property, in Seller's possession, custody or control.

EXHIBIT D

Assignment of Leases

THIS ASSIGNMENT AND ASSUMPTION OF LEASES AND SECURITY DEPOSITS (the "**Assignment**") is made as of the ____ day of _____ 201_, by and between _____, ___, a _____ ("**Seller**"), and _____, ___, a _____ (hereinafter referred to as "**Purchaser**").

1. Reference to Agreement of Sale. Reference is made to a Purchase Agreement dated the ___ day of _____ 201_, between Seller and Purchaser pursuant to which Seller has agreed to sell to Purchaser, and Purchaser has agreed to purchase from Seller, the improved real property and other assets described therein (the "**Agreement**"). Capitalized terms used herein and not otherwise defined herein shall have the meanings set forth in the Agreement.

2. Assignment. For good and valuable consideration received by Seller, the receipt and sufficiency of which are hereby acknowledged, Seller hereby grants, transfers and assigns to Purchaser all right, title and interest of Seller in and to the Leases, all security deposits and lease guarantees relating to such Leases. The representations, warranties, covenants and agreements made in the Agreement by Seller are true and correct as of the date of this Assignment and shall survive the execution and delivery of this Assignment for the period of time set forth in the Agreement. By execution hereof, Purchaser does hereby assume and agree to perform all duties, obligations, and responsibilities of landlord and/or property owner under the Leases first arising from and after the date hereof. **THIS ASSIGNMENT IS IN ALL RESPECTS SUBJECT TO THE PROVISIONS OF THE AGREEMENT AND IS NOT INTENDED IN ANY WAY TO SUPERSEDE, LIMIT OR QUALIFY ANY PROVISION OF THE AGREEMENT.**

3. Binding Effect. This Assignment and the representations, warranties, covenants and agreements herein contained shall inure to the benefit of Purchaser and its successors and assigns and shall bind Seller and its successors and assigns.

IN WITNESS WHEREOF, Seller and Purchaser have each executed this Assignment as of the date first written above.

WITNESS/ATTEST:

_____

SELLER:

_____, ___

By: _____
Name: _____
Title: _____

WITNESS/ATTEST:

_____

PURCHASER:

_____, ___

By: _____
Name: _____
Title: _____

EXHIBIT E

BILL OF SALE

THIS BILL OF SALE (this "**Bill of Sale**") is made and delivered as of _____, 2015 by _____, ___, a _____ ("**Seller**"), pursuant to that certain Purchase Agreement dated as of ____ ___, 2015 (the "**Agreement**"), made by and between Seller and _____, ___, a _____ (hereinafter referred to as "**Purchaser**").

For purposes of this Bill of Sale all capitalized terms used in this Bill of Sale and not otherwise defined shall have the meanings given to such terms in the Agreement.

KNOW ALL MEN BY THESE PRESENTS, that, for the consideration described in the Agreement, the receipt and sufficiency of which are hereby acknowledged by Seller, Seller hereby sells, transfers, assigns and delivers unto Purchaser, and its successors and assigns, all of the right, title and interest of Seller in and to all of the Personal Property.

TO HAVE AND TO HOLD all of such Personal Property, together and singular, unto Purchaser, and its successors and assigns, to and for its and their use forever.

AND Seller hereby represents and warrants to Purchaser, and its successors and assigns, that it has good and marketable title to the Personal Property and to each item comprising the Personal Property, free and clear of all security interests, mortgages, pledges, liens, restrictions, encumbrances, leases, charges and title defects whatsoever, and that Seller has full right and power to sell, transfer, assign and deliver the Personal Property and each item comprising the Personal Property.

The representations, warranties, covenants and agreements made in the Agreement by Seller are true and correct as of the date of this Bill of Sale and shall survive the execution and delivery of this Bill of Sale for the period of time set forth in the Agreement. **THIS BILL OF SALE IS IN ALL RESPECTS SUBJECT TO THE PROVISIONS OF THE AGREEMENT AND IS NOT INTENDED IN ANY WAY TO SUPERSEDE, LIMIT OR QUALIFY ANY PROVISION OF THE AGREEMENT.**

This Bill of Sale and the representations, warranties, covenants and agreements herein contained shall inure to the benefit of Purchaser and its successors and assigns and shall bind Seller and its successors and assigns.

IN WITNESS WHEREOF, Seller has caused this Bill of Sale to be executed in its name and on its behalf by its duly authorized officer, intending it to constitute an instrument under seal, on the date first above written.

_____, ___

Dated: _____, 2015

By: _____(SEAL)
Name: _____
Title: _____

EXHIBIT F

Assignment of Permits and Warranties

THIS ASSIGNMENT OF PERMITS AND WARRANTIES (this "**Assignment**") is entered into on this___ day of _____ 2015, by _____, ___, a _____ ("**Seller**") and _____, ___, a _____ (hereinafter referred to as "**Purchaser**"), pursuant to that certain Purchase Agreement dated as of _____ ___, 2015 (the "**Agreement**"), made by and between Seller and Purchaser. Capitalized terms used herein and not otherwise defined herein shall have the meanings set forth in the Agreement.

1. Assignment. For good and valuable consideration received by Seller, the receipt and sufficiency of which are hereby acknowledged, Seller hereby grants, transfers and assigns to Purchaser all right, title and interest of Seller (if any) in and to the Permits and Warranties. The representations, warranties, covenants and agreements made in the Agreement by Seller are true and correct as of the date of this Assignment and shall survive the execution and delivery of this Assignment for the period of time set forth in the Agreement. **THIS ASSIGNMENT IS IN ALL RESPECTS SUBJECT TO THE PROVISIONS OF THE AGREEMENT AND IS NOT INTENDED IN ANY WAY TO SUPERSEDE, LIMIT OR QUALIFY ANY PROVISION OF THE AGREEMENT.**

2. Binding Effect. This Assignment and the representations, warranties, covenants and agreements herein contained shall inure to the benefit of Purchaser and its successors and assigns and shall bind Seller and its successors and assigns.

IN WITNESS WHEREOF, Seller has executed this Assignment effective as of the day and year first above written.

_____, ___

_____

By: _____ (Seal)
Name: _____
Title: _____

EXHIBIT G

Contracts

MAHC 30-Day Readmission Rate
All Cause, All Payers
CY2014

Maryland facilities (6)	15%
Pennsylvania facilities (5)	15%
Delaware facilities (1)	14%

Source: MAHC

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

DFMC
DELMARVA FOUNDATION
Maryland

ICPC Quarterly Scorecard

January 1, 2009 to December 31, 2012
Maryland

Report Date: June 1, 2013

This material provided by Delmarva Foundation for Medical Care (DFMC), the Medicare Quality Improvement Organization (QIO) for Maryland, was prepared by Colorado Foundation for Medical Care (CFMC), the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-MD-CT-071713-353.

Introduction

The Integrate Care for Populations and Communities (ICPC) Quarterly Scorecard is a report designed to help Quality Improvement Organizations (QIOs) monitor and evaluate the progress of the nation, states, US territories, and communities involved in the 10th Scope of Work (SOW) ICPC Aim. QIOs will receive an updated Scorecard following submission of the QIO Quarterly Deliverables. The Scorecard is based on the most recent C.3 Monthly Community/Provider Log and the most current ASAT data file to which the NCC has access. Note that the most recent quarter of data may not be fully mature.

Changes and Updates

Additions

- Map showing ZIP Code level percent of hospitalizations that are out of state (Nation and State section)
- Table showing ZIP Code level percent of hospitalizations that are out of state. Only those ZIP Codes for which the out-of-state percentage is in the top decile of the nation are shown. (Appendix 2)

Deletions

- Community metrics and maps for previously reported communities whose ZIP Codes and hospitals remain unchanged. This affects the following tables and maps:
  - ZIP Code level admissions per 1,000 benes maps
  - ZIP Code level 30-day readmissions per 1,000 benes maps
  - Admissions/Readmissions by Hospital
  - Admissions/Readmissions by ZIP Code
- All state maps (IC-7 and IC-8) and statewide coalition maps (IC-5a, IC-5b, IC-6a, and IC-6b) if all community ZIP Codes and hospitals remain unchanged

Of Note

Several QIOs have requested that the Scorecard include tables for the proportionate readmission rate (readmissions/live discharges). This information is included in the "Post-Acute Care Setting Readmission Rates" table in the Appendix. The next to last column reported as (G=D/A) calculates the rate of readmissions per live discharges.

Navigating the Scorecard

The Quarterly Scorecard includes a Table of Contents listing the numerous tables, figures, and maps. To navigate to any of these elements, hover your mouse over the title or page number, press and hold the Ctrl key, and left click your mouse simultaneously. To return to the title page, press Ctrl+Home.

Interpreting the Scorecard

The Quarterly Scorecard is divided into five sections: 1) National; 2) State; 3) Statewide Coalition; 4) Statewide Engaged Communities; and 5) Community. Each section contains a set of summary tables and figures reflecting population-based admission and readmission metric trends, admission and readmission metrics pertaining to specific diagnoses, post-acute care settings, and emergency department visits and observation stays. Each Quarterly Scorecard also highlights a variety of maps that visually display admission and readmission metrics. Note that the maps and table depicting ZIP Code level percent of hospitalizations that are out of state are claims-based and not population-based which means that a beneficiary who is hospitalized multiple times will be counted multiple times.

Because the Scorecard relies on the exact data reported in the C.3 Monthly Community/Provider Log, QIOs must resolve potential errors found in this report on subsequent C.3 Monthly Community/Provider Logs for the changes to be reflected within future Quarterly Scorecards.

Community Designations

Engaged QIO Community: Any community reported in the QIO's most recent C.3 Monthly Community/Provider Log. This is analogous to the QIO Community designation used for maps.
Recruited QIO Community: Any community marked as formally recruited in the C.3 Monthly Community/Provider Log regardless of recruitment date. Recruited QIO communities are designated by an asterisk (*) in the Table of Contents and Community section of the Scorecard.
CCTP Partner: Community-based Care Transitions Program (CCTP) Partners officially announced by the Centers for Medicare & Medicaid Services (CMS). CCTP Partners are designated by a double dagger (‡) in the Table of Contents and Community section of the Scorecard.
Formal CT Program (Non-CCTP): Any community accepted into a formal Care Transitions (CT) program (other than CCTP) as determined by CMS. Formal CT Program (Non-CCTP) communities are designated by a dagger (†) in the Table of Contents and Community section of the Scorecard.
ADRC Option D Communities: Any community that has been awarded a CT Option D grant from the Aging and Disability Resource Centers (ADRC) as determined by CMS. These communities are displayed on the national maps.

Cohort Designations

National: All Medicare fee-for-service (FFS) beneficiaries residing in any valid ZIP Code in the 50 States, District of Columbia, Puerto Rico, and the United States (US) Virgin Islands.
State: All Medicare FFS beneficiaries residing in any valid ZIP Code in the state. ZIP Codes that cross state lines are assigned based on the SAS zipstate function.
Statewide Coalition: All Medicare FFS beneficiaries residing in the ZIP Codes associated with recruited QIO communities in the IC-5 and IC-6 metrics. This section includes both the Coalition A and Coalition B designations of the IC-5 and IC-6 metrics. If ZIP Codes are the same for both the 'A' and 'B' designations, the Scorecard will not display results for the 'B' statewide coalition cohort. For all other metrics, only Coalition 'A' is displayed.

Statewide Engaged Communities: All Medicare FFS beneficiaries residing in the ZIP Codes associated with all QIO communities as reported in the QIO's most recent C.3 Monthly Community/Provider Log. All communities with associated ZIP Codes, regardless of recruitment status, are included in these aggregate metrics.
Community: All Medicare FFS beneficiaries residing in the ZIP Codes associated with each engaged QIO community as reported in the most recent C.3 Monthly Community/Provider Log. Communities in the log, but without associated ZIP Codes, are not included. These tables and figures include beneficiaries residing in out-of-state ZIP Codes associated with the engaged community.

Note: The 'baseline' time period is included in this report. However, the rates presented here do not reflect official baseline rates to be used for evaluation. Also note that the addition of the cohorts used for IC-5a, IC-5b, IC-6a, and IC-6b are based on the most recent C.3 Monthly Community/Provider Log. They do not represent official baseline or interim results. These additional metrics use the exact ZIP Codes as entered in the most recent C.3 Monthly Community/Provider Log, not the 'locked down' ZIP Codes entered in the July 31, 2012 C.3 Monthly Community/Provider Log. These metrics use the most recent ASAT data pull. For these reasons, the Scorecard metrics may not match the baseline numbers you received nor can they be used for official evaluation purposes.

Figures (see glossary for definitions)

Quarterly Admissions and Readmissions: Each of the five cohort sections displays graphs of admissions and readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. The graphs display both observed and seasonally adjusted values.

Seasonally Adjusted Quarterly Admissions by Cohort: The state section displays seasonally adjusted admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition (both 'A' and 'B' designations, where applicable), and each engaged community with associated ZIP Codes in the QIO's C.3 Monthly Community/Provider Log. The community section displays seasonally adjusted admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition, and the designated community.

Seasonally Adjusted Quarterly Readmissions by Cohort: The state section displays seasonally adjusted readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition (both 'A' and 'B' designations, where applicable), and each engaged community with associated ZIP Codes in the QIO's C.3 Monthly Community/Provider Log. The community section displays seasonally adjusted readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition, and the designated community.

Quarterly Emergency Department Visits/Observation Stays: Each of the five cohort sections includes a graph displaying Emergency Department Visits, Observation Stays, and Admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. Please note that these metrics are not seasonally adjusted and may show seasonal effects.

Quarterly Diagnosis-Specific Admissions: Each of the five cohort sections includes a graph displaying Diagnosis-Specific Admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. Please note that these metrics are not seasonally adjusted and may show seasonal effects.

Quarterly Diagnosis-Specific Readmissions: Each of the five cohort sections includes a graph displaying Diagnosis-Specific Readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. Please note that these metrics are not seasonally adjusted and may show seasonal effects.

Annual Post-Acute Care Setting Readmissions: Each of the five cohort sections includes a pie chart displaying discharges to various post-acute care settings for calendar year 2011. The outer circle represents setting-specific discharges while the inner circle displays discharges with and without associated 30-day readmissions within the specified setting.

Tables (see glossary for definitions)

Admissions and Readmissions by Hospital: The community section includes tables displaying admissions and readmissions by hospital among Medicare FFS beneficiaries residing in the ZIP Codes associated with the community. Hospitals with no associated claims within the time period of interest are not displayed. These tables will only be displayed for new communities or communities with associated ZIP Code or hospital changes.

Admissions and Readmissions by ZIP Code: The community section includes tables displaying admissions and readmissions by ZIP Code among Medicare FFS beneficiaries residing in the ZIP Codes associated with the community. These tables will only be displayed for new communities or communities with associated ZIP Code or hospital changes.

Appendix Tables (see glossary for definitions)

The following tables are included for each of the five cohorts and display quarterly, semi-annual, and annual metrics.

Admissions and Readmissions: These tables show the admissions and 30-day readmissions for eligible beneficiaries residing in the ZIP Codes associated with the designated cohort.

For the admissions and readmissions per 1,000 quarterly metrics, the *Observed* column represents the total number of admissions and readmissions per 1,000 beneficiaries while the *Seasonally Adjusted* column represents the number of admissions and readmissions per 1,000 beneficiaries after adjusting for seasonal effects.

The quarterly denominator (eligible beneficiaries) for the observed measure is consistent across the quarters. However, admissions and readmissions show seasonal effects. These effects could be due to a variety of issues, including more hospitalizations in winter months, number of days in the quarter, and major holidays in the quarter (lower 'elective' admissions). Therefore, comparisons using the observed measure should be made using the same quarter of the year (e.g., Q1 2009 to Q1 2010). To compare other quarters or consider trends, the seasonally adjusted metrics should be used.

To determine the seasonal effects, we computed quarterly rates for each of the 20 quarters from Q1 2006 through Q4 2010 using a national inpatient file. We then calculated the average rate of all 20 quarters (Overall Mean). Next, we calculated a residual for each of the 20 quarters (difference between each of the 20 quarterly rates and the Overall Mean). The seasonal adjustments reflect the mean of the residuals at each of the four quarters (e.g., Q1 is the average of all 5 Q1s - Q1 2006, Q1 2007, Q1 2008, Q1 2009, Q1 2010). Finally, we computed the seasonally adjusted rates as the observed minus the quarterly adjustment.

ZIP Code Level Percent of Hospitalizations that are Out of State: Provided for each state, this table shows the number of in-state, out-of-state, and total hospitalizations as well as the percent of total hospitalizations that are at out-of-state hospitals. Only those ZIP Codes for which the out-of-state percentage is in the top decile of the nation are shown. It should be noted that point ZIPs and ZIP Codes with ten or less hospitalizations might be included in the table, but are not included in the maps.

Emergency Department (ED) Visits and Observation Stays (Obs): Medicare often disperses payments for inpatient admissions, observation stays, and emergency department visits based on hierarchical rules since each claim can only count as one of these three types. The related tables show the breakdown of claims in each category: ED visits, Obs stays, and inpatient admissions. For a further explanation of the hierarchical rules used to assign a claim into one of these categories refer to the webex "ED Visits/Observation Stays per 1000 Beneficiaries" located on the ICPC National Coordinating Center (NCC) website (http://www.cfmc.org/integratingcare/qios_reference.htm).

Diagnosis-Specific Admissions and Readmissions: These tables show admissions and readmissions among beneficiaries for the following six disease categories: acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), chronic renal failure, congestive heart failure, diabetes mellitus, and pneumonia.

Post-Acute Care Setting Readmission Rates: These tables show the number and percent of patients discharged to each of four post-acute care settings: Home Health Agency (HHA), Home, Hospice, and Skilled Nursing Facility (SNF). Also included are the number and percent of those patients readmitted within 30 days.

Note: The post-acute care settings are determined by the discharge status code on the index claim (HSE_CLM_STUS_CD). As such, readmission measures do not necessarily reflect the patient setting immediately prior to readmission but rather the intended setting immediately following the index discharge.

Maps

The National (section 1), State (section 2), Statewide Coalition (section 3) and Community (section 5) sections contain a series of maps intended to depict visual information about beneficiary hospital utilization as well as communities involved in care transitions efforts at the national, state, and community levels.

The maps display calendar year 2011 admissions and readmissions per 1,000 beneficiaries by ZIP Code for the following cohorts:

- National (all valid ZIP Codes in the 50 states, District of Columbia, Puerto Rico and the US Virgin Islands).
- State (all ZIP Codes in the state).
- Statewide Coalition (both 'A' and 'B' designations, where applicable).
- Community (all ZIP Codes in the community).

The majority of the maps display the admissions and readmissions per 1,000 beneficiaries metrics by ZIP Code which enables the viewer to visualize potential areas of higher admissions or readmissions within the cohort. Generally, the ZIP Codes for the national and state (IC-7 and IC-8) maps are sorted into deciles of admissions or readmissions per 1,000, with each decile representing approximately 1/10 of the cohort's associated ZIP Codes. The ZIP Codes for the statewide coalition (both 'A' and 'B' designations, where applicable) and the community maps are sorted into quintiles of admissions or readmissions per 1,000, with each quintile representing approximately 1/5 of the cohort's associated ZIP Codes. Legend values are based solely on ZIP Codes that contain area; therefore, point ZIP Codes are not represented in these maps. Admission and readmission metrics for ZIP Codes with 10 or fewer beneficiaries are not displayed on any of the maps due to confidentiality restraints. These areas do not have any red, yellow, or green shading but are symbolized using a black hatch pattern on a white background. If these areas are within a community, they will also be displayed beneath a community designation layer. These designation layers are symbolized with either a black, blue, or turquoise border with a black, blue, or turquoise stipple (evenly distributed dot pattern) interior.

National and state maps each include an overlay of the following community designations:

- Engaged QIO communities, designated as 'QIO Communities' with associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a black border and a black stipple (evenly distributed dot pattern) interior. The border is based on contiguous ZIP Codes. If a community has noncontiguous ZIP Codes, it may appear as multiple communities on the map. In addition, some ZIP Codes that appear to be contiguous do not actually touch (e.g., a river is between them). If a community has this phenomenon, it may look like more than one community on the map.
- CCTP Partners, as reported by CMS, with associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a royal blue border and a royal blue stipple (evenly distributed dot pattern) interior.
- CCTP Partners, as reported by CMS, without associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a royal blue circular border and royal blue stipple (evenly distributed dot pattern) interior. The circles surround arbitrary community epicenters.
- Formal CT Program (Non-CCTP), as reported by CMS, with associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a turquoise border and a turquoise stipple (evenly distributed dot pattern) interior.
- ADRC Option D Communities. These communities are symbolized with a fuchsia border and a fuchsia stipple (evenly distributed dot pattern) interior. ADRC communities are defined by counties rather than ZIP Codes. These communities are included for those who might wish to work collaboratively to improve care transitions. These communities are only represented on the National maps.

The Statewide Coalition section of the Quarterly Scorecard includes maps for both the 'A' and 'B' designations, where applicable. If the ZIP Codes for the 'A' and 'B' designations are identical, only Coalition 'A' is displayed. The Statewide Coalition 'A' designation consists of communities recruited by 7/31/12 that were not accepted into a formal CT program by 7/31/12. The Statewide Coalition 'B' designation consists of communities recruited by 7/31/12 that were not accepted into a formal CT program by 7/31/12 or any time thereafter. Maps in the Community section of the Quarterly Scorecard are only displayed for new or modified communities with associated ZIP Codes in the QIO's C.3 Monthly Community/Provider Log.

The National and State sections also contain a map visually depicting the percent of hospitalizations that are out of state for calendar year 2011 data at the ZIP Code level. The ZIP Codes are sorted into deciles, with each decile representing approximately 1/10 of the ZIP Codes in the nation. Legend values are based solely on ZIP Codes that contain area; therefore, point ZIP Codes are not represented in these maps. Percentages for ZIP Codes with 10 or fewer hospitalizations are not displayed on any of the maps due to confidentiality restraints. These areas do not have any shading, but are symbolized using a black hatch pattern on a white background. The state map is a zoomed-in view from the national map, providing a higher level of detail due to the larger scale. Acute Care and Critical Access Hospitals appear on the state map to help the viewer better understand out-of-state hospitalization patterns.

Glossary

Admissions per 1,000 Benes: Number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort per 1,000 eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Admissions (Percent): Number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, within the designated group (hospital or ZIP Code), divided by the total number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, multiplied by 100.

Admissions (Number): Number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Beneficiaries (Eligible): Number of Medicare FFS beneficiaries at risk for hospitalization who reside in the ZIP Codes associated with the designated cohort.

Beneficiaries (Percent): Number of Medicare FFS beneficiaries at risk for hospitalization who reside in the specified ZIP Code divided by the total number of Medicare FFS beneficiaries at risk for hospitalization who reside in any ZIP Code associated with the designated community, multiplied by 100.

Coalition A: A cohort designation for the statewide coalition consisting of ZIP Codes associated with communities recruited as of 7/31/12 **including** those accepted into a formal Care Transitions Program after July 31, 2012.

Coalition B: A cohort designation for the statewide coalition consisting of ZIP Codes associated with communities recruited as of 7/31/12 **excluding** those accepted into a formal Care Transitions Program after July 31, 2012.

Description: Description of the Clinical Classification Software (CCS) diagnosis category.

Discharges: Discharges among eligible Medicare FFS beneficiaries at risk for hospitalization who reside in the ZIP Codes associated with the designated cohort.

Emergency Department (ED) Visits: The number of emergency department visits among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

End Date: End date for the time period of interest.

Hospital Name: The hospital name associated with the hospital ID as indicated in the HLTH_SERV_PROVIDER table in Complex 1.

IC-5a: Readmissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **including** those accepted into a formal Care Transitions Program after July 31, 2012.

IC-5b: Readmissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **excluding** those accepted into a formal Care Transitions Program after July 31, 2012.

IC-6a: Admissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **including** those accepted into a formal Care Transitions Program after July 31, 2012.

IC-6b: Admissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **excluding** those accepted into a formal Care Transitions Program after July 31, 2012.

ID: The identification number of the hospital as listed in the QIO's C.3 Monthly Community/Provider Log. 'Other' indicates aggregate metrics for hospitals not listed in the C.3 Monthly Community/Provider Log.

Observations (Obs) stays: The number of observation stays among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Observed: The total number of admissions or readmissions per 1,000 beneficiaries.

Point ZIPs: ZIP Codes that do not contain area such as post offices or military bases.

Readmissions per 1,000 Benes: Number of readmissions within 30 days of hospital discharge among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort per 1,000 eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Readmissions (Number): Number of readmissions within 30 days of a hospital discharge among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Readmissions (Percent): Number of readmissions within 30 days of a hospital discharge among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, within the designated group (hospital or ZIP Code), divided by the total number of readmissions among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, multiplied by 100.

Seasonally Adjusted: The number of admissions and readmissions per 1,000 beneficiaries after adjusting for seasonal effects.

Start Date: Start date for the time period of interest.

Stays: Number of observation stays among eligible FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Visits: Number of Emergency Department visits among eligible FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

ZIP Code: The US Post Office ZIP (Zone Improvement Plan) Code of the postal region of interest.

Appendix 2: Maryland

Table 2.22: Annual Post-Acute Care Setting Readmission Rates

Skilled Nursing Facility (SNF)

		Discharges			30 Day Readmissions			Rates	
Start Date	End Date	Total (A)	To SNF (B)	% To SNF (C=B/A)	Total (D)	From SNF (E)	% From SNF (F=E/D)	% of All Discharges Readmitted (G=D/A)	% of Discharges to SNF Readmitted (H=E/B)
01/01/2009	12/31/2009	248,139	47,339	19.08%	55,735	12,865	23.08%	22.46%	27.18%
04/01/2009	03/31/2010	245,786	47,050	19.14%	54,621	12,606	23.08%	22.22%	26.79%
07/01/2009	06/30/2010	245,014	46,824	19.11%	54,003	12,337	22.85%	22.04%	26.35%
10/01/2009	09/30/2010	243,670	46,552	19.10%	53,434	12,177	22.79%	21.93%	26.16%
01/01/2010	12/31/2010	242,691	46,748	19.26%	52,932	11,905	22.49%	21.81%	25.47%
04/01/2010	03/31/2011	243,270	47,355	19.47%	52,871	12,012	22.72%	21.73%	25.37%
07/01/2010	06/30/2011	240,853	47,106	19.56%	52,040	11,781	22.64%	21.61%	25.01%
10/01/2010	09/30/2011	239,193	46,597	19.48%	51,221	11,533	22.52%	21.41%	24.75%
01/01/2011	12/31/2011	238,538	46,375	19.44%	50,923	11,490	22.56%	21.35%	24.78%
04/01/2011	03/31/2012	235,989	45,238	19.17%	49,745	11,029	22.17%	21.08%	24.38%
07/01/2011	06/30/2012	233,984	44,639	19.08%	49,048	10,737	21.89%	20.96%	24.05%
10/01/2011	09/30/2012	232,214	44,195	19.03%	48,330	10,487	21.70%	20.81%	23.73%
01/01/2012	12/31/2012	229,241	43,306	18.89%	46,917	10,038	21.40%	20.47%	23.18%

Figure 2.7: Annual Post-Acute Care Setting Readmissions

Appendix 3: Maryland Statewide Coalition

Table 3.24: Annual Post-Acute Care Setting Readmission Rates

Skilled Nursing Facility (SNF)

		Discharges			30 Day Readmissions			Rates	
Start Date	End Date	Total (A)	To SNF (B)	% To SNF (C=B/A)	Total (D)	From SNF (E)	% From SNF (F=E/D)	% of All Discharges Readmitted (G=D/A)	% of Discharges to SNF Readmitted (H=E/B)
01/01/2009	12/31/2009	96,479	17,535	18.17%	23,286	5,237	22.49%	24.14%	29.87%
04/01/2009	03/31/2010	96,191	17,327	18.01%	23,006	5,093	22.14%	23.92%	29.39%
07/01/2009	06/30/2010	95,984	17,265	17.99%	22,630	4,958	21.91%	23.58%	28.72%
10/01/2009	09/30/2010	96,007	17,398	18.12%	22,605	4,983	22.04%	23.55%	28.64%
01/01/2010	12/31/2010	95,296	17,532	18.40%	22,271	4,834	21.71%	23.37%	27.57%
04/01/2010	03/31/2011	95,957	17,907	18.66%	22,300	4,876	21.87%	23.24%	27.23%
07/01/2010	06/30/2011	95,221	17,724	18.61%	22,071	4,775	21.63%	23.18%	26.94%
10/01/2010	09/30/2011	94,449	17,434	18.46%	21,654	4,594	21.22%	22.93%	26.35%
01/01/2011	12/31/2011	94,769	17,262	18.21%	21,795	4,618	21.19%	23.00%	26.75%
04/01/2011	03/31/2012	93,885	16,982	18.09%	21,363	4,487	21.00%	22.75%	26.42%
07/01/2011	06/30/2012	93,232	16,986	18.22%	21,106	4,413	20.91%	22.64%	25.98%
10/01/2011	09/30/2012	92,743	17,155	18.50%	20,831	4,406	21.15%	22.46%	25.68%
01/01/2012	12/31/2012	91,450	17,109	18.71%	20,196	4,258	21.08%	22.08%	24.89%

Figure 3.5: Annual Post-Acute Care Setting Readmissions

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 other service(s). See additional instruction in the column to the right of the table.

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	$630,000		$630,000
(4) Other - Bed Purchase	$550,000		$550,000
SUBTOTAL Other Capital Costs	*$3,364,353*		$3,364,353
TOTAL CURRENT CAPITAL COSTS	$18,103,021	$0	$18,103,021
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	$18,103,021	$0	$18,103,021
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	*$19,588,417*	*$0*	*$19,588,417*
B. Sources of Funds			
1. Cash	$5,088,417		$5,088,417
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	$14,500,000		$14,500,000
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	*$19,588,417*		$19,588,417
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.

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 instructions in the column to right of the

	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	$ 1,890,708	$ 9,050,036	$ 9,502,178	$ 9,502,178	$ 9,502,178
b. Outpatient Services					
Gross Patient Service Revenues	***$ 1,890,708***	***$ 9,050,036***	***$ 9,502,178***	***$ 9,502,178***	***$ 9,502,178***
c. Allowance For Bad Debt	$ 36,363	$ 188,526	$ 196,176	$ 196,994	$ 197,580
d. Contractual Allowance					
e. Charity Care					
Net Patient Services Revenue	***$ 1,854,345***	***$ 8,861,510***	***$ 9,306,002***	***$ 9,305,185***	***$ 9,304,598***
f. Other Operating Revenues (Specify)	$ (32,568)	$ 376,258	$ 306,634	$ 347,497	$ 376,823
NET OPERATING REVENUE	***$ 1,821,777***	***$ 9,237,768***	***$ 9,612,636***	***$ 9,652,682***	***$ 9,681,421***
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	$ 234,703	$ 842,615	$ 882,330	$ 882,330	$ 882,330
c. Interest on Current Debt					
d. Interest on Project Debt	$ 316,085	$ 641,731	$ 572,784	$ 572,784	$ 572,784
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)	$ 659,177	$ 2,551,486	$ 2,671,190	$ 2,670,373	$ 2,669,786
TOTAL OPERATING EXPENSES	**$ 3,170,512**	**$ 9,168,461**	**$ 9,279,915**	**$ 9,279,098**	**$ 9,278,511**

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 instructions in the column to right of the

	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**
3. INCOME					
a. Income From Operation	**$ (1,348,734.59)**	**$ 69,307.32**	**$ 332,721.55**	**$ 373,584.32**	**$ 402,910.31**
b. Non-Operating Income					
SUBTOTAL	***$ (1,348,734.59)***	***$ 69,307.32***	***$ 332,721.55***	***$ 373,584.32***	***$ 402,910.31***
c. Income Taxes	$ -		$ 119,618.74	$ 119,618.74	$ 119,618.74
NET INCOME (LOSS)	***$ (1,348,734.59)***	***$ 69,307.32***	***$ 213,102.82***	***$ 253,965.58***	***$ 283,291.57***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare	47.5%	31.4%	31.7%	31.5%	31.5%
2) Medicaid	45.5%	54.2%	54.7%	54.5%	54.3%
3) Blue Cross					
4) Commercial Insurance	5.3%	6.3%	6.4%	6.3%	6.3%
5) Self-pay	3.4%	4.1%	4.1%	4.1%	4.1%
6) Other	-1.8%	4.0%	3.1%	3.5%	3.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days					
1) Medicare	31.0%	20.0%	20.0%	20.0%	20.0%
2) Medicaid	59.5%	69.0%	69.0%	69.0%	69.0%
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 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 instructions in the column to right of the

	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	$ 1,925,580	$ 9,259,918	$ 9,721,914	$ 9,721,914	$ 9,721,914
b. Outpatient Services					
Gross Patient Service Revenues	***$ 1,925,580***	***$ 9,259,918***	***$ 9,721,914***	***$ 9,721,914***	***$ 9,721,914***
c. Allowance For Bad Debt	$ 37,122	$ 193,102	$ 200,972	$ 201,789	$ 202,375
d. Contractual Allowance					
e. Charity Care					
Net Patient Services Revenue	***$ 1,888,457***	***$ 9,066,816***	***$ 9,520,943***	***$ 9,520,126***	***$ 9,519,539***
f. Other Operating Revenues (Specify)	$ (29,459)	$ 395,189	$ 326,665	$ 367,528	$ 396,854
NET OPERATING REVENUE	***$ 1,858,998***	***$ 9,462,006***	***$ 9,847,608***	***$ 9,887,653***	***$ 9,916,393***
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	$ 250,049	$ 935,224	$ 979,522	$ 979,522	$ 979,522
c. Interest on Current Debt					
d. Interest on Project Debt	$ 316,122	$ 641,341	$ 572,057	$ 572,057	$ 572,057
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)	$ 665,610	$ 2,590,292	$ 2,711,905	$ 2,711,088	$ 2,710,501
TOTAL OPERATING EXPENSES	**$ 3,192,327**	**$ 9,299,486**	**$ 9,417,096**	**$ 9,416,278**	**$ 9,415,692**

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 instructions in the column to right of the

	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**
3. INCOME					
a. Income From Operation	**$ (1,333,328.90)**	**$ 162,519.81**	**$ 430,512.26**	**$ 471,375.03**	**$ 500,701.02**
b. Non-Operating Income					
SUBTOTAL	***$ (1,333,328.90)***	***$ 162,519.81***	***$ 430,512.26***	***$ 471,375.03***	***$ 500,701.02***
c. Income Taxes	$ -	$ -	$ 158,735.02	$ 158,735.02	$ 158,735.02
NET INCOME (LOSS)	***$ (1,333,328.90)***	***$ 162,519.81***	***$ 271,777.24***	***$ 312,640.01***	***$ 341,966.00***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare	50.4%	35.3%	35.6%	35.4%	35.3%
2) Medicaid	42.6%	50.5%	51.0%	50.8%	50.6%
3) Blue Cross					
4) Commercial Insurance	5.2%	6.2%	6.2%	6.2%	6.2%
5) Self-pay	3.3%	4.0%	4.0%	4.0%	4.0%
6) Other	-1.6%	4.1%	3.3%	3.6%	3.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days					
1) Medicare	33.6%	23.0%	23.0%	23.0%	23.0%
2) Medicaid	56.9%	66.0%	66.0%	66.0%	66.0%
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%***

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:	Villa Rosa Nursing and Rehab, LLC Attn: Steven Wynn, Administrator	**From:**	OHCQ/Long Term Care Unit Ranada Cooper
Fax:	301-429-2731	**Pages:**	8
Phone:	301-459-4700	**Date:**	11/13/2014
Re:	2567 for 11/06/14 survey	**CC:**	

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

• Mr. Wynn:

Attached please find the CMS-2567 for the life safety code survey completed by OHCQ at your facility on 11/06/14. 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

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 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 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

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 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 Safey 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.

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

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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 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 11:50 AM and 1:00 PM the State Fire Marshal observed that the deficienices 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)		

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 056)	Continued From page 2	(K 056)		
	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 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.	(K 147)		

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:	Villa Rosa Nursing and Rehab Attn: Steven Wynn	**From:**	OHCQ/Long Term Care Unit 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.

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

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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 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

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

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{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 it will be done on a monthly basis moving forward. Findings will be reported to the facility's safety and quality assurance committee. The committees will take appropriate action if needed. Corrective actions will be completed by December 5, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8DEC14

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.

Wynn, Steven

From:	Fisher, Wayne
Sent:	Monday, December 08, 2014 7:02 AM
To:	Wynn, Steven; Bob Lanza; McGuire, Paul; Skinner, Castro; Robertson, Edward
Cc:	Grillo, Jeff
Subject:	FW: Villa Rosa; Electrical Modifications
Attachments:	doc4180672014120217393 8.pdf
Importance:	High

Here is the letter from Tomey Electric.

From: David Tomey [mailto:dtomey@tomeyelectric.com]
Sent: Monday, December 08, 2014 6:56 AM
To: Fisher, Wayne
Cc: Chad Hardin; Adam Tomey; Amy Albert
Subject: Villa Rosa; Electrical Modifications
Importance: High

Wayne,

Per your request, Chad and Tyler spent a long day at the Villa Rosa Nursing and Rehabilitation Center at 3800 Lottsford Vista Road in Mitchellville, Maryland 20721 with the directive to test, verify, repair/replace any electrical outlets that are required to be GFCI protected by the 2011 NEC. In addition, the Fire Marshal recommended the light switches located in the shower rooms be GFCI protected. In a phone conversation between David Tomey and Bill Routson (Fire Marshal), it was agreed to replace the stainless steel switch plates to a non-conductive nylon with nylon screws in lieu of installing GFCI breakers since ground fault detection is not required by NEC for the lights and/or associated switches.

Listed below are the tasks preformed which we assume to bring the entire facility into compliance with the code:

Basement Area:

1. Men's & Women's Lockers; Change Stainless Steel plates to nylon with nylon screws for switches in showers (one each locker).
2. Laundry Room; tested one (1) GFCI by sink, tested OK.
3. Elevator equipment room; two (2) GFCI tested OK.
4. Storage closet; replaced one receptacle with GFCI and installed raised receptacle cover

1st Floor A Wing:

1. Social Services Administration; tested OK
2. Business office; replace one receptacle with GFCI
3. Cloyster; two (2) counter receptacles replaced with GFCI receptacles.
4. Shower 113; replaced switch screws with nylon screws for three switches
5. Patient room 101; tested OK
6. Patient room 103; tested OK
7. Patient room 105; tested OK
8. Patient room 109, 110, 111, 112, 115, and 117; tested OK
9. Patient room 106; replaced GFCI by bathroom door and changed switch cover to nylon with nylon screws
10. Patient room 108; replaced receptacle with GFCI outside bathroom door.

1st Floor B Wing:

1. Kitchen/dinning; tested five (5) GFCI receptacles all good
2. Shower 126; replaced switch covers and nylon screws for two switches
3. Rehabilitation; tested one GFCI, OK
4. Inspected the gym; OK

5. Patient room 118; tested one GFCI OK and replaced one receptacle with GFCI which tested OK
6. Patient room 120; OK
7. Patient room 122, 124, 128, and 130; tested and OK

1st Floor C Wing:

1. Men's & Women's Bathrooms; replaced two (2) stainless plates and screws to nylon in each bath
2. Nurses station; tested two (2) GFCI, OK
3. Bathroom 118; tested two (2) GFCI, OK
4. Patient room 119, 120 121, 122, 123, 124 , 125, 126; tested OK

1st Floor D Wing:

1. Bathroom; checked one GFCI OK
2. Solarium; OK
3. Patient room 105-114; GFCI tested OK
4. Patient room 105-114 vanity light receptacles; disconnected
5. Bathroom 101 was currently under construction; Bopat Electric was installing GFCI to the circuit

2nd Floor A Wing:

1. Patient room 200, 202, 203, 204, 206-211 , 215 and 217; tested OK
2. Patient room 205 (Janitor's Closet); replaced receptacle with GFCI

2nd Floor B Wing:

1. Rooms 216, 218, 219, 220, 221, 222, 223, 224, 225, 227, 228, 232, 233, 235, 237 and 239; tested OK
2. Room 229 missing a plate on the GFCI; replaced plate and tested OK

2nd Floor C Wing:

1. Men's & Women's bathrooms; tested OK
2. Oxygen Room; tested OK
3. Patient room 213, 214, 215, 217, 218, 219, 220 , 222 and 224; tested OK
4. Patient room 216; replaced receptacle with GFCI tested two (2) GFCI both OK
5. Patient room 221; replaced receptacle with GFCI tested two (2) GFCI both OK

2nd Floor D Wing:

1. Bathroom 201; changed screws to nylon on two (2) switches
2. Beauty Parlor; replaced one receptacle with GFCI, checked three (3) additional, all OK
3. Solarium; tested OK
4. Patient room 203-209 and 211; tested OK

Exterior of the Building:

1. Outside patio; GFCI tested OK
2. Outside yard by auditorium; No ground on circuit. Disconnected receptacle and installed blank plate.
3. Receptacle by basement door; tested OK
4. Receptacle inside generator enclosure; tested OK

To the best of our knowledge we are complete as of last Friday. Tyler also assisted the onsite maintenance personal ("Ed") to develop a list of the GFCI protected devices to facilitate monthly testing in the future. Please advise if there is anything else that we can be of service to provide.

David A. Tomey
TOMEY ELECTRIC, INC.
5430 Handley Road
Cambridge, MD 21613-3483
410-228-8130 Voice

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.

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

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF
LONG TERM CARE RESIDENTS PROTECTION

September 19, 2013

Ayokunie Ayanleye, Administrator
Delmar Nursing and Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940-1110

RE: Second Follow-up Survey ending – September 18, 2013

Dear Mr. Ayanleye:

I wish to thank your staff for the courtesy shown to the surveyor who conducted the second follow-up Federal Certification Survey ending September 18, 2013 to the two Complaint Surveys that ended May 10, 2013 and June 12, 2013 and the first follow-up survey that ended August 15, 2013. The survey findings show that your facility has regained substantial compliance with Federal participation requirements as of September 18, 2013. Enclosed are copies of the CMS-2567and the CMS-2567B Post-Certification Revisit Report showing corrected deficiencies for your file. Also enclosed is the State Survey Report.

If you have any questions, please contact me at 302-577-6661.

Sincerely,

Robert H. Smith

Robert H. Smith
Licensing and Certification Administrator

RHS/mam

Enclosures

cc: Timothy Hock, CMS, Chief Enforcement Branch
Victor Orija, LTC Ombudsman
Renee Purzycki, MSW, DLTCRP
Richard McKee, DLTCRP
File

3 MILL ROAD, SUITE 308, WILMINGTON, DE 19806
TELEPHONE: (302) 577-6661 • 1-877-453-0012 • FAX: (302) 577-6672

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

December 15, 2014

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

CMS Certification Number: 215350

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Mr. Wynn:

Our letter of November 4, 2014 indicated that a denial of payments for new admissions was being imposed on your facility effective November 21, 2014.

The Maryland Office of Health Care Quality State survey agency conducted a revisit of your facility on December 10, 2014, and has determined that your facility is once again in substantial compliance with Medicare requirements. Your facility continues to participate in the Medicare and Medicaid programs. The denial of payments for new admissions was in effect November 21, 2014 through December 5, 2014.

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

Sincerely,

Dale Van Wieren

Dale Van Wieren, Manager
Certification and Enforcement Branch

AGE SPECIFIC CARE

All staff taking on-line class yearly.

COURSE DESCRIPTION

This Course is part of the Health and Safety Compliance Training Curriculum. This course explains the JCAHO age specific expectations. This course will give you a better understanding of why age-specific characteristics are incorporated into the workplace scope and responsibilities.

COURSE OBJECTIVES

At the completion of this course you should be able to:

- Articulate and integrate JCAHO age-specific expectations into the planning, implementation, continuation and evaluation of care.
- Understand why we incorporate age-specific characteristics into our workplace scope and responsibilities

OUTLINE

- JCAHCO Standards
- Age Specific Care
- Pediatric Care
- Adolescent Care
- Geriatric Care

Envisioning your future in a nursing home

Margaret P. Calkins, Ph.D.

President, IDEAS Inc.

Board Chair, IDEAS Institute

Founding member and Board Member, SAGE

Ask any gathering of people – if they had to move into a nursing home tomorrow, would they want to share a room with someone they had never met before? Especially if the room looked like a hospital room with the beds separated by a piece of fabric? I have done this, and I can tell you the answer is a resounding, "NO!"

Ask the family members of someone who has just passed away in a nursing home whether they didn't visit as often, or as long, or whether some family members did not come at the end, because there wasn't enough space in the room, and they felt like they were impinging on the rights of the roommate to have their own room. Or whether the presence of the roommate kept them from being able to say the things that needed to be said before this individual died. Or whether they were disturbed because the roommate had dementia, and kept coming over and interrupting conversations and picking up things they had brought.

Ask the roommate how she felt, wanting to go into her room to take a nap but not wanting to disturb the family who was gathering, also knowing they didn't want to disturb her or disrupt her routine. Or how she felt 3 months ago when her roommate couldn't make it to the bathroom, and so used a commode chair next to the bed, but couldn't pull the curtain either. Ask her how embarrassed she was when her roommate did this in front of her visitors.

Ask the staff how much time they spend trying to manage roommate conflict. When one person likes to stay up late and watch TV, with the volume so loud the roommate can't get to sleep. When one prefers music to game shows, or when the person near the thermostat (and who therefore controls the thermostat) likes the room warmer than the roommate, or when the person near the bed likes the curtains closed all day so she can sleep, and the roommate complains to everyone who will listen, and even to those who don't listen anymore, because they're heard it all before and there's nothing they can do about it anyway. The "complainer" complains louder and louder, and then her family starts complaining, so the social worker tries to make peace, but fails. So they decide to move the complainer, but the only person she'll share a room with already has a roommate, so the facility has to force 2 other residents to move, just to keep the peace and stop the complaining. Ask staff how they feel about all this.

These are all commonplace events in the daily life of the majority of nursing home residents who share a bedroom with a stranger.

History

Originally conceived of as sub-acute hospitals, nursing homes were built on the same institutional model. Large open wards were thought to be the most efficient, in those early days before call bell system, because staff could see all the patients who stayed in bed most of the time. Over time, the wards became smaller, to the point where 4 and 6-person bedrooms were the norm. At the same time, patients in nursing homes were being encouraged to get out of bed and go to the central "day room" (another institutional concept) to socialize. But problems persisted. Several studies show that people in shared rooms, particularly rooms without a clearly defined territory for each individual, are less social in shared or public areas of the unit, and more territorial in claiming space, be it a section of the hallway or a chair in the day room (Kinney, Stephens, & Brockman, 1987; Lipman, 1967; Nelson & Paluk, 1980). In other words, when people do not have sufficient privacy and personal territory provided through the physical environment, they create their own social and psychological privacy by limiting their interactions with other people.

Private vs. semi-private

CMS Tag F460 (§483.70(d)(1)(iv)) states that bedrooms "be designed or equipped to assure full visual privacy for each resident." The interpretive guidelines suggest that "full visual privacy" means that residents have a means of completely withdrawing from public view while occupying their bed (e.g., curtain, moveable screens, private room)." Typically, when a room is shared with one or more persons, it is described as semi-private. What is semi-private? It is an oxymoron. It is a little like being "slightly

pregnant." Let's start with an examination of privacy. The American Heritage dictionary defines private as "secluded from the sight, presence, or intrusion of others; designed or intended for one's exclusive use" (American Heritage nd). Dictionary.com defines it as "without the presence of others; alone" (Dictionary.com, nd).

Semi-private, on the other hand, is defined as "of, receiving, or associated with hospital service giving a patient more privileges than a ward patient but fewer than a private patient" (Merriam Webster, nd) or "shared with usually one to three other hospital patients" (American Heritage, 2000). In both of these definitions, semi-private is defined in terms of being in a hospital, whereas the definitions for privacy never mentioned being in a hospital. Thus, it is reasonable to question how "semi-private" came to be defined solely in terms of being in a hospital. One definition refers to "privileges" though it is unclear what those privileges are. The reality is that privacy, in a semi-private room, refers only to visual privacy (as stated in CMS Tag 460). That's what a so-called (or mis-named) "privacy" curtain does—limits visual privacy. It does nothing to protect the privacy of auditory or olfactory information, or control over who comes into a space.

There are clearly different kinds of privacy- as the current concern over identity theft proves. Identity theft is loss of control over one's personal information. Identity theft is not dissimilar from what happens in a nursing home when staff discuss diagnoses and personal care issues with a person on their side of a room, when the roommate is present separated only by a piece of fabric. Despite the intentions of HIPPA, it is just not practical to keep all diagnostic and care issues private from a roommate. So it can be

argued that care in a shared room will almost certainly involve HIPPA violations. If there is more than one roommate (CMS Tag F457 states bedrooms must accommodate no more than 4 residents), HIPPA violations are virtually guaranteed.

In reality, though, keeping information private is generally not at the top of the list of issues or concerns to people living in shared rooms. Much more important to them is adjusting to the day-to-day routines, behaviors and activities of another person. Hearing someone moaning constantly, seeing them use their bedside commode, listening to their TV shows, not being able to set the temperature the way you want, not be able to keep the door open (or closed) as is your preference, having their clothing take up more than half of the closet—these are the everyday irritants that cause friction among roommates. These are issues of basic control over the environment. A resident can't even keep people out of their room, if the roommate wants to let them in.

Not being able to have a private conversation is cited by family members as an important issue. Many nursing homes have few shared social spaces and they are often occupied, so finding a location other than the bedroom to have a private conversation can be difficult. Furthermore, nursing home residents are frail and tire easily, so it may be more convenient to visit in the bedroom. But if there is a roommate, this can stifle the ability to spend quality time together. Bedrooms tend to be so small that there is seldom room for more than one person to visit at a time or more than one chair, limiting the number of people who can visit, or impinging on the space of the roommate. CMS Tag 248 gives minimum requirements of 80 square foot per person in a shared room and 100 square foot

for a private room, but with furniture and wheelchair and other mobility devices, possibly oxygen or other medical support devices, there is barely room for a single chair, much less two to have a conversation with a visitor. This is an especially sensitive issue at end-of-life. Families and loved ones want to gather at the bedside of the dying individual. But there is tension between wanting to have everyone important there and knowing that the presence of large numbers of people is even more disruptive to the roommate. In most cases, the roommate is equally unhappy by the situation, feeling awkward and forced to be an unwilling participant in what ought to be a private time for families. This problem is compounded with there are more than two people sharing the room. It is even less likely that a gathering family can find any time alone with their dying relative.

Having a roommate is not necessarily always a completely negative experience. Anecdotally, administrators, nurses and social workers will say that there are some people who really prefer not to live alone, who do better with the companionship of a roommate. One research project specifically explored the relationship between roommates in nursing homes (Bitzan, 1998). In this study, 22% of residents interviewed indicated an overall strong or positive emotional bond with their roommate (which is higher than in many other studies), although this means that 77% had moderate or weak emotional bond with their roommate. Overall, 80% denied having problems getting along with their roommate. However, 80% also denied any intimacy of sharing problems or concerns with their roommate. The majority of roommates did not enjoy spending time with their roommate, did not perceive their roommate to be sensitive to their feelings, and agreed they got along best when they kept their feelings and activities to

themselves. Another study (Terakawa, 2004) explored satisfaction of residents who lived in shared rooms and then moved into a new building with all private rooms. Although 39% of the residents initially indicated complete satisfaction with having a roommate and did not want to have a private room, by eight months after the move, 100% of the residents were completely satisfied with having a private room. This suggests people may tolerate and even accommodate to having a roommate, when it's necessary (making the best of it), but once they've had the opportunity to experience living in a private room, that's what they prefer.

Other Factors

Satisfaction is only one factor that is impacted by being in a private or a shared room. There are also clinical consequences, most notably in the area of nosocomial infections. Virtually every study that has explored this topic, both in hospitals and in nursing homes, found patients/residents living in shared rooms were at a significantly higher risk of nosocomial infections (clostridium difficile-associated diarrhea, antibiotic-associated diarrhea, methicillin-resistant staphylococcus aureus, influenza A, acute nonbacterial gastroenteritis and pneumonia) than their counterparts in private rooms (Boyce, Potter-Bynoe, Chenevert & King, 1997; Drinka, Krause, Nest, Goodman, & Gravenstein, 2003; Harkness, Bentley & Roghmann 1990; *State Ombudsman Data: Nursing Home Complaints*, 2003). Nursing home residents contract more than 1.5 million infections annually, have a median incidence rate of 1 to 1.2 per 1,000 patient-days, and each resident faces a 5% to 10% risk per year of infection (Furman, Rayner & Tobin, 2004; Zimmerman, Gruber-Baldini, Hebel, Sloane & Magaziner, 2002). These infections

(primarily pneumonia and influenza A) account for almost 1/4 of hospitalizations of nursing home residents (Zimmerman, Gruber-Baldini, Hebel, Sloane & Magaziner, 2002). One study followed all nursing home admissions to 59 nursing homes in Maryland over a 2.5 year period. Of 2,153 admissions, there were 4,903 episodes of infections in 1,267 residents, of which 375 (7.6%) required a hospital admission (Boockvar, Gruber-Baldini, Burton, Zimmerman, May & magaziner, 2005). Another study specifically looked at the differential risk of acquiring influenza A in private and shared rooms, and found "those who lived in double rooms with roommates who were identified as cases had a higher relative risk of acquiring influenza A of 3.07 (95% confidence interval, 1.61 to 5.78) compared with those who lived in single rooms" (Drinka, Krause, Nest, Goodman, & Gravenstein, 2003). Finally, a study conducted in 1994 estimated that the average cost of hospitalizing a nursing home resident to treat pneumonia to be $7500 (Lave, Lin, Hughes-Cromwick & Fine, 1999). Since most of these infections are difficult and expensive to treat, and increase risk of mortality, this is a particularly significant issue for both patients and the health care system at large.

There are other financial implications. Preliminary research also suggests that it is more difficult to market a shared bedroom, resulting in significant lost revenue when people choose a different facility because it has a private room available. The impact of this can be seen in the construction cost analysis conducted by Calkins and Cassella (2007). After analyzing 189 bedroom plans and developing a detailed cost analysis, the average cost of construction plus capital costs (debt) of a traditional, side-by-side shared room was found to be $41,012 or $20,506 per person, while the average cost of a private room was

$36,515 (2005 dollars). Thus, it costs $16,009 more per person to build private versus traditional shared rooms. Stated another way, it costs $32,018 more to build two private rooms than one shared room. This would seem to support those who say that private rooms are too expensive to build. But taking a life-cycle costing approach, it can be demonstrated that this difference in construction cost is not as great as it might appear. Based on a large national study, the average daily cost of a private room in a nursing home is $23 more than a shared room. If the beds are all occupied, assuming a $23 dollar a day difference, it would take 1.9 years to recoup the cost differential of building 2 private rooms versus 1 shared room. However, if the facility cannot fill a bed in a shared room, the lost revenue is not $23, but $167 per day —the average daily cost of a shared bedroom. At $167 a day it takes only 6.4 months to recoup the construction and debt differential (Calkins & Cassella, 2007).

Medicaid, which is the largest payor source for nursing homes, in general will not pay more for a private room. However, in Michigan, the legislature approved a $5/day higher reimbursement for nursing homes that constructed private rooms. Even with a higher reimbursement of just $5/day, the construction/capital cost differential is recouped in less than 9 years, meaning the facility is ahead financially for 21 years (calculations assumed a 30 year mortgage). Thus, if a facility is concerned about their long-term finances, it may make more sense to have more private rooms than shared rooms.

Staff Factors

There is some evidence, albeit slim, that staff also prefer it when more residents are in private rooms. Calkins and Cassella (2007) conducted focus groups in nursing homes, were direct care workers said they had a easier time with residents who lived in private rooms than in shared rooms. Maintenance and housekeeping also suggested their activities took longer in shared rooms, possibly because the rooms were more crowded or because residents in shared rooms felt like the space was more "public" (especially the bathroom) and didn't work to keep it clean, whereas residents in private rooms treated it more like their own bathroom at home, keeping it cleaner. There is also some evidence that staff turnover may be lower in units with a higher percentage of private rooms (Degenholtz, 2007). Both of these factors should be examined more carefully. Given the estimates that construction accounts for about 6% of the life-cycle cost of a nursing home and consumables 11% to 16%. staffing accounts for roughly 66%-78% (Hiatt 1989). Therefore, spending more money on construction in ways that increase staff efficiencies and reduce staff costs could save money in the long run.

Other Alternatives

Thus far, the discussion has been about traditional, side-by-side shared rooms versus private rooms. In fact, there are other alternatives. There are a variety of shared bedroom configurations where each person has their own space, their own territory, their own window, but share a bathroom. The figures below show two examples of these different configurations.

Toe-to-toe Enhanced Shared Room

L-Shaped Enhanced Shared Room

None of the research reported above on satisfaction or nosocomial infections addressed the style of the shared room, so there is not empirical data on how these "enhanced" shared rooms are perceived by residents and family, or might impact the spread of various infections. There is some anecdotal evidence that staff and residents prefer these enhanced rooms over traditional shared rooms (reported in Calkins & Cassella, 2007). In one interview, a resident was asked how she liked this shared room arrangement, and she replied that she "didn't have a shared room, though I do have to share the bathroom, which is sometimes a problem. But I have my own room here" (Calkins, 2005). It is not possible at this time to do a similar cost analysis as was done above for traditional shared and private rooms, because there is no cost information available on these enhanced shared rooms.

Summary

There is clear and convincing evidence that the traditional shared bedroom, with two beds along the same wall, is associated with poor clinical and psychosocial outcomes in nursing home residents. The financial cost to the healthcare system of treating nosocomial infections is substantial. The average cost (in 1994 dollars) of hospitalization for an infection was $7500, and this has undoubtedly increased in the intervening years. But even at $7,500, it only takes 4 ½ hospitalizations to recoup the cost differential of constructing two private rooms instead of one traditional shared room. Given the high rate of nosocomial infections in nursing homes in general, and the high relative risk

(3.07) of acquiring an infection when living in a shared room over being in a private room (Drinka, Krause, Nest, Goodman, & Gravenstein, 2003), it is likely that these healthcare costs might be recouped within a few years with private rooms. Unfortunately, because nursing homes do not pay for the costs of these hospitalizations, the potential cost savings serve as less of an incentive to them. Policy makers, however, should be concerned with the potential for significant cost savings. The savings to Medicare of these prevented hospitalizations is significant. More research that specifically examines rates of infections and hospitalizations by room type (private, traditional shared or enhanced shared) is needed.

It is more difficult to put a concrete price on the lower satisfaction of residents in shared rooms. Certainly, low satisfaction is contrary to the goal of maximizing quality of life for residents in nursing homes, which is at the very heart of the culture change movement. It also has some financial implication for facilities, in lower census and therefore lost revenue because people refuse to move into a shared room.

Given these findings, regulators should give serious consideration to revising codes to disallow new construction of the traditional, side-by-side shared room. The enhanced shared rooms may be an acceptable alternative, but there has simply not been enough research that examines this style of bedroom to say definitively one way or the other how they impact psychosocial and clinical outcomes and costs. There are sufficient differences within this style or category of room in terms of layout, which impacts degree of auditory privacy and territoriality, that research needs to be very specific in what

variables it considers. Finally, those facilities that are looking to position themselves as the place of choice for the coming Baby Boom generation will do well to provide a significant majority of private rooms.

Recommendations

Recommendations

1) Change regulations to prohibit new construction of traditional, side-by-side shared rooms.
2) Change regulations to disallow 4-person rooms.
3) Change regulations to prohibit the use of a "privacy" curtain as an allowable separator between people who share a room. Privacy should be defined to include acoustic privacy and the right and ability to close a door between two separate parts of the shared room.
4) Increase minimum room size to 125 square foot for a private, and 125 per person in a shared room (exclusive of toilet room)
5) Fund research to examine in greater depth the differences between traditional shared, enhanced shared rooms (accounting for differences in layout that affect privacy and control) and private rooms across the following variables/outcomes of interest:
    a. Rate of nosocomial infections
    b. Rate of hospitalizations
    c. Rate of falls
    d. Resident, family and staff satisfaction
    e. Staff turnover
    f. Census
    g. Operational cost factors (differentials in staff time for care and cleaning/maintenance)

6) Develop easy-to-use MDS analytic tool that facilities can use to track differential outcomes and costs associated with their different bedroom configurations
7) Modify Medicaid/Medicare funding calculations to take into account cost savings accrued to the system from reduced infections and hospitalizations of individuals in private rooms.
8) Culture Change Coalitions and other advocates should work to educate state legislators (who often control state codes) on the value of private versus shared rooms for both quality of life and quality of care/costs.
9) Teach surveyors/give regulators the tools to more deeply assess satisfaction with roommate situation by room type. Of critical concern is control/lack of control residents have over whether they have a roommate and who that individual is.
10) Use results of research (#2, above) examining the life-cycle costs of constructing larger and/or more private rooms, to revise building codes and reimbursement formulas to support the least expensive life-cycle costs with acceptable outcomes (satisfaction and quality of life), not just the least expensive initial construction costs.

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Nelson·Tremain Partnership
ARCHITECTURE AND DESIGN FOR AGING
125 Southeast Main Street · Minneapolis, Minnesota 55414 · phone (612) 331-7178 · fax (612) 331-8255

Gaius G. Nelson, SMArchS, NCARB
President, Nelson·Tremain Partnership

Household Models for Nursing Home Environments

There will always be a need for long term, medically supervised, personal care settings. Current financing and care models dictate that these settings group individuals together for efficiency. At the same time, studies point to the positive effects resulting from social interaction. The form these settings take, depends not only upon the vision and resources that sponsoring organizati ons offer, but also to the approach regulatory agencies use to protect public health, safety and welfare. This paper examines concepts that influence the design of long -term care settings, demonstrates several newer household typologies, and suggests regul atory modifications that would enable further development of this new generation of nursing home.

Form Follows Regulation

For many years, the program brief for the design of nursing homes was based upon the regulatory model of an institutional based setting. This began with the publication of the original *General Standards* in 1947 for the implementation of the Hill -Burton requirements for health care facilities. This later became the *Minimum Requirements of Construction and Equipment for Medical Facilities* that set down the design requirements for nursing homes participating in Medicare and Medicaid programs (Guidelines 1996 - 1997).

The Hill-Burton requirements were a set of prescriptive regulations defining minimum standards of design and construction. Prescriptive requirements included elements such as: maximum number of residents per sleeping room; minimum square feet per patient within a sleeping room; minimum square feet of dining and activity space per patient; minimum quantities of toilet and bathing fixtures per patient; maximum travel distance from a nursing station to each patient room door; and requirements for visualization of the corridor from the nursing station.

Prescriptive requirements led to a situation where architects and designers used the regulations as the basis for all planning and design decisions. Due to cost constraints, minimum requirements quickly became maximum allowable quantities and sizes of facilities, and in some jurisdictions, these maximums were mandated. Such mandates no t to exceed particular size requirements grew from a fear that the state government may need to take over and operate poorly performing facilities. It only makes common sense that a facility with more square feet per patient is more costly to operate than a smaller facility.

Over time, nursing homes began to look alike, with large nursing stations, situated to provide direct view, down a series of double-loaded corridors, radiating from a central observation point. This unintended similarity of outcomes is what I refer to as *Form Follows Regulation* a situation where regulations seem to dictate the ultimate form of the physical environment.

Hierarchy of Space

The field of Environmental Psychology is based upon the concept that the physical environment has a significant impact in shaping the actions of individuals and groups. The layout and composition of spaces can either inhibit or encourage social interaction among individuals. Similar to the way a line of chairs set in rows at a bus depot discourage int eraction, double loaded corridors, lined with adjacent bedrooms, allow little oppo rtunity to socialize. This type of spatial organization is referred to as *sociofugal*, space that separates people. To promote interaction one should create *sociopetal space*, space that brings people together in groupings that face one another (Osmund 1957).

Another important concept that must be considered in the arrangement of space is what I refer to as the *Hierarchy of Space*. This is a spatial concept that refers to the pr ogression of space in terms of access and activity. The progression is often defined as four different zones: *Private; Semi-private; Semi-public; and Public* (Howell 1980) (Figure 1). Each of these zones moves progressively from the individual control and s afety of one's private space to increased opportunity for interaction with others in the public realm. All zones are important and are required to live life completely.

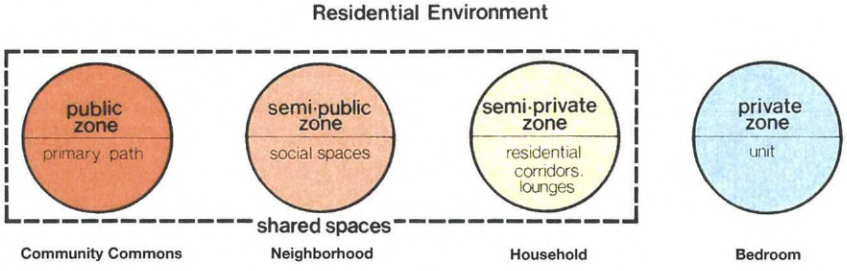


Figure 1

This progression of the physical environment is of particular importance to older people who are increasingly vulnerable to abrupt changes in environmental stimuli. They may no longer possess the resiliency to moderate this environmental press, or impact that the physical environment can impose. Unfortunately, within the typical nursing home the hierarchy of space is truncated into only two zones, private and semi -public. There is little opportunity for life that is not either confined to the private zone of one's bedroom (if one considers a shared bedroom private), or as a lonely bystander within the semi -public zone of large, undifferentiated dining rooms, dayrooms and corridors.

An early concept for improving the hierarchy of space within nursing homes was proposed in *Designing the Open Nursing Home* (Koncelik 1976) (Figure 2). This design took the typical lounge or dayroom of the institutional model, often found at the end of the corridor, divided it into smaller areas and relocated the space as a "front porch" between the private resident bedroom and the public corridor space. These transitional semi -public/semi -private spaces provided a zone referred to as the "corridor neighborhood" offering opportunities for personalization and a variety of visual stimuli, reducing the typical repetition of corridors.

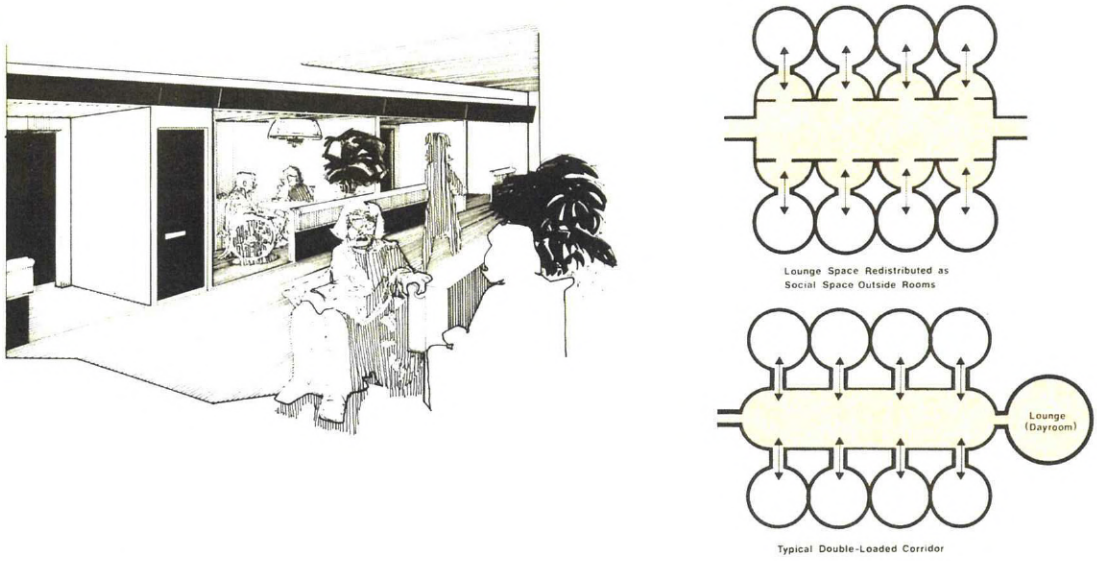


Figure 2

Designing the Open Nursing Home
Joseph A. Koncelik, 1976

Quality of Life

Until the Omnibus Reconciliation Act (OBRA) of 1987 little progress was made in the advancement of designs for nursing home environments beyond the traditional hospital -based institution. Even today, radial wings of double -loaded corridors with a majority of side -by-side semi -private bedrooms are still being constructed. But with the advent of OBRA 1987, nursing home operators were required to consider resident rights, autonomy, choice, control and dignity. Many forward -thinking operators saw this also as a mandate to significantly change the institutional design model of the physical environment.

Enhancing *Quality of Life* for residents has become a requirement. Yet little research or guidance exists to help facility operators and designers understand what it means to provide a life of quality.

Some organizations have conducted resident, family and staff *satisfaction surveys* to help understand how they are performing in the eyes of their constituents. Though helpful to some extent, these surveys provide little new information with regard to the physical environment. Regulators, architects and designers are not the only groups that are unable to break away from the institutional model that has been the standard for so many years. Residents, families and staff can only know the types of nursing home environments they have experienced.

The CMS State Operations Manual speaks in detail to many of the psycho-social aspects related to *Quality of Life* such as Dignity (F241), Self-Determination and Participation (F242), Participation in Activities (F245) and Activities (F248). But when it comes to direction with regard to the physical Environment (F252), it offers only that "The facility must provide a safe, clean, comfortable and homelike envi ronment." And goes further to indicate that the environment must be "sanitary and orderly" (F253), provide "private closet space" (F255), "adequate and comfortable lighting" (F256), comfortable and safe temperature levels" (F257) and finally "comfortable s ound levels" (F258). Only the last five requirements have any direct relationship to the design of the physical environment and provide very little

guidance indeed. Yet it is understandable that such requirements be performance-based rather than prescripti ve in nature. It is extremely difficult to define what is, or is not "homelike," or how one might actually create "home" within institutional settings.

The American Institute of Architects (AIA) Guidelines for the Design of Healthcare Facilities is a cons ensus-based standard that provides much greater detail in its design guidance. Developed as both a regulatory document for adoption by legislative authorities, and as a guide to best practices, the document provides both minimum standards and educational g uidance. Through the use of appendix material that sits adjacent to the regulatory language, designers and regulators are able to directly compare minimum requirements with newer design concepts. The appendices often serve as an introduction for new materi al that, in subsequent editions of the document, is adopted as requirements. The AIA Guidelines are a building design guide that works to avoid definition of operational requirements.

To Live in Fullness

Wikipedia defines *Quality of Life* as "the degree o f well-being felt by an individual or group of people" (en.wikipedia.org/wiki/Quality_of_life). Though not tangible or measurable, quality of life may be thought of as being comprised of two components: the physical and the psychological. Physical definitions of well-being would include ones level of health and safety. These are the aspects that have traditionally been heavily regulated within the long-term care environment, often to the detriment of psychological well-being.

It is the psychological aspect s of well-being that offer the greatest potential to inform the way that physical environments for long-term care are conceived and constructed. Studies investigating the psychological concept of *Flow* provide much information.

Flow describes a state of be ing where one is completely immersed in an activity to the extent that one loses track of time. It is often associated with sporting activities where the concentration and effort required are closely matched to the challenge. In

sports it may be know n as being in the groove. In religious settings, as a state of ecstasy.

Flow is the experience of "being in harmony with what we *Wish, Think, and Feel*" (Csyikszentmihalyi 1997) being at one with the moment, so much so, that we lose ourselves to the task at hand as well as the sense of time. We have all heard the saying: "Time flies when you're having fun." The satisfaction that results from Flow experiences provides a true measure of the Quality of Life.

What is most helpful are studies that looked at the Flow potential of everyday activities (Csyikszentmihalyi 1997). In these studies, people were asked to document their activities, whether alone or in groups, and their feelings about the activities. Unlike many studies that rely upon the memories of individual s entering their daily activities into a diary at the end of the day these studies required extemporaneous documentation at random intervals throughout the day. This methodology provides remarkable insight into the activities, feelings and participants inv olved in everyday living.

Within the studies, daily activities are broken into three categories that each occupy approximately one third of our waking hours. These activities include *Productive Activities, Maintenance Activities,* and *Leisure Activities.* The following chart indicating how people experience the various categories of activities and provides knowledge as to how we feel about w hat we do on a day-to-day basis (Figure 3).

The Quality of Experience in Everyday Activities

Based on daytime activities reported by representative adults and teenagers in recent U.S. studies, the typical quality of experience in various activities is indicated as follows:
- negative; — very negative; • average or neutral; + positive; ++ very positive

Productive Activities	Happiness	Motivation	Concentration	Flow
Working at work or studying		-	—	++ +
Maintenance Activities				
Housework	-	-	•	-
Eating	++	++	-	•
Grooming	•	•	•	•
Driving, transportation	•	•	+	+
Leisure Activities				
Media (TV and reading)	•	++	-	-
Hobbies, sports, movies	+	++	+	++
Talking, socializing, sex		++	++	• +
Idling, resting	•	+	-	—

Sources: Csikszentmihalyi and Csikszentmihalyi 1988; Csikszentmihalyi and Graef 1980; Csikszentmihalyi and LeFevre 1989; Csikszentmihalyi, Rathunde, and Whalen 1993; Kubey a nd Csikszentmihalyi 1990; and Larson and Richards 1994.

Figure 3
(Csyikszentmihalyi 1997)

From this analysis it was found that those daily activities that produce the greatest potential to generate an experience of Flow include: Working, Studying, Drivin g, Hobbies, Sports, Movies, Talking, Socializing, and Sex.

Life is *What we do, How we feel about it,* and *Who we do it with* (Csyikszentmihalyi 1997). The chart above tracks the first two elements, but it is the third, with *whom* we participate with in these activities, that adds a dimension to further enhance the experience.

Though a solitary engaged mind and body can provide much satisfaction, Csyikszentmihalyi finds that "we depend upon the company of others" to live a life of fullness. "Over and over again, findings suggest that people get depressed when they are alone and they revive when they rejoin the company of others." He goes on to say, "The importance of friendships on well -being is difficult to overestimate. The quality of life improves immensely when there is at least one other person willing to listen to our troubles and support us emotionally."

Much of what the study found is that, "a typical day is full of anxiety and boredom. Flow experiences provide the flashes of intense living against thi s dull background." This points to the notion that in order to improve quality of life, one must engineer one's daily life to maximize participation in high Flow potential activities. Or as care providers, we must provide the opportunities to participate i n activities that are engaging and challenging within a setting that enables the development of relationships.

At the Walden School in Vermont, students follow the philosophy of Henry David Thoreau by continually asking themselves three questions: *What is my relationship to myself? What is my relationship to culture? What is my relationship to the natural world?* (waldenschoolvt.org) In a similar fashion, it is helpful in the design of long-term care environments within a *culture change* milieu to think in t erms of relationships. Focusing solely on the person or resident, as in *resident-centered care* or *person-directed care*, limits our thinking. Q uality of life is enhanced when we consider the totality of experience within *Relationship-Enabling Environments*.

The Nursing Home - As Institution

Clearly, the traditional institutional model of the nursing home falls far short of providing an environment that enables a fulfilling quality of life. The physical environment of institutions are sociofugal in nature, l acking in the appropriate hierarchy of spaces and provide little to enhance quality of life in resident' relationships with themselves, the community, or nature. Early concepts toward improving the physical environment provided only modest steps forward. R egulatory hurdles including health care design guidelines, building codes, life safety codes, food safety regulations, and a plethora of overlapping state and local health and safety requirements are all focused upon maintaining the institutional model of nursing home construction.

This institutional bias proved a difficult obstacle to overcome. As the image of nursing homes became less desirable to residents and families, alternatives such as assisted living began to appear in the marketplace. These alter natives provide an attractive image to residents and families, in many cases advertising themselves as "nursing home alternatives" through the provision of home health

care and visiting nursing services. Conformance to less restrictive residential codes an d regulations help to achieve the desired "homelike" feel by allowing narrower corridors, elimination of the central nurse station and creation of smaller more intimate settings. Many in the long -term care industry predicted the end of nursing homes.

At the same time, many operators and designers were embarking on an alternative approach, not to supplant, but to reform the vision of the nursing home. Designs appeared with high proportions of private rooms, and shared rooms providing enhanced environments where each resident received separate sleeping areas with *each their own window* and furnishings, sharing only the room entry and toilet facilities. Corridors were shortened, nursing stations became less pronounced within nursing units of 36 -45 residents as opposed to the traditional 60 beds. Smaller decentralized clusters or pods that provided small -scale social settings closer to resident rooms were created. Staff support areas, including small work desks were also decentralized to increase staff efficiency by locating direct -care staff closer to resident bedrooms.

Most of these newer cluster concepts, however, are still corridor -based schemes with inconsistent or incorrect hierarchies of space where semi -public corridors pass directly outside of private bedrooms with little or no transition zone. Still, the institutional bias prevails due to requirements that all rooms open onto corridors that are physically separated from spaces as protection from smoke and fire, and that allow direct visual supervision of staff on a 24 -hour basis. These requirements and many others conspire against the creation of a true home for residents.

The Household - A Relationship-Enabling Environment

The Household model can be described as a living ar rangement where all activitie s of daily living occur within a small -scaled environment, reminiscent of a large family home. This type of living arrangement has been used for many years as group home settings for developmentally disabled populations. The first use of the term *household* in a skilled nursing home setting described Evergreen Manor in Oshkosh, Wisconsin as "two neighborhoods with dining and bathing facilities shared by three "households" of six

private rooms which in turn share family rooms and kitchenettes" (Architectural Record, April 1988).

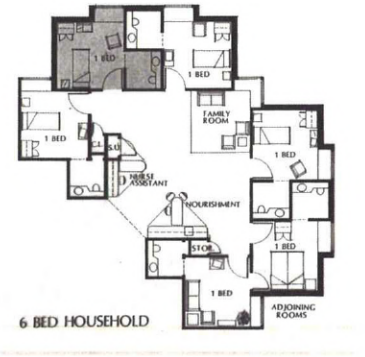


Figure 4
(Gaius G. Nelson @ KKE, 1987)

The initial concept (Figure 4), designed by this author in 1987, was developed ten years later into the fully formed household model by taking the crucial step of including the di ning room within its nine resident household environment as a country kitchen. Opened in 1997, the fully operational Creekview at Evergreen Retirement Community is described as "a creative effort to rethink the nature of skilled care organizationally as we ll as architecturally" (DESIGN '98, 1998). Subsequent refinement of the household/neighborhood model resulted in the 2005 addition at Evergreen Retirement Community of *Creekview South* utilizing households of eleven residents each (Figure 5).

Figure 5

The household model provides an environment that is immediately understandable to residents and visitors as a setting that has been a natural part of everyday life. Individuals intrinsically know how to act within a household. All activities of daily living occur within closely related *private* or *semi-private* zones that are discrete from other portions of the facility.

In addition to private or shared resident slee ping rooms with their own bath room with toilet (and sometimes shower), households typically contain a living room, dining room, kitchen, and common bathing facilities. Often an additional, flexible activity space is included for use as a quiet room or small conference/work space. Open access to a secure bac kyard directly available to residents, enables a continuing relationship to the natural environment. Support areas for staff include a workspace used for storage of medicine and supplies as well as necessary paperwork, a soiled utility room, storage of cle an and soiled items and equipment for laundering personal clothing.

The small scale of the household, with its open floor plan, virtually eliminates corridors and allows orientation and easy access for residents to all daily activities.

Living Room at Creekview

Partnership

Dining Room at Creekview

Backyard at Creekview

The households at Creekview South are each part of a larger nursing unit known as a *Neighborhood*. Four households of eleven residents each are connected together through a *Neighborhood Center*. This organization (Figure 6) provides clearly defined geographic zones of responsibility for *resident assistants* within each household and the *team manager* for the entire neighborhood. Support is provided to each neighborhood and household from the adjoining CCRC campus through central services including procurement, housekeeping, commercial laundry (not resident clothing), and food service that provides prepared bulk food for individual plating from steam wells at each country kitchen.

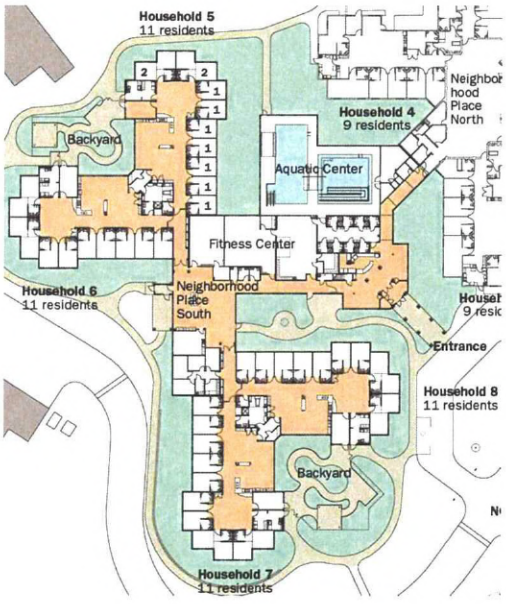


Figure 6

The Green House® and Small House models of the household offer a complete break with the institutional nature of traditional nursing homes. "Intended to be a self -contained home for a group of 7-10 elders…a Green House® blends architecturally with other homes in its neighborhood" (The Gerontologist, Vol. 46, No. 4, pg. 538). It is envisioned that eventually these types of small, self - contained facilities could be developed as parts of typical residential neighborhoods with one or more "houses" integrated into the community.

The Green House® concept was developed by Dr. Bill Thomas. He states: "We wanted there to be a heart, a center , a focus of the house. So you know, what you have in the hearth is sort of food on one end, fire on the other, and a place to share convivium or the pleasure of a good meal sort of in the middle." He continues "We've always insisted in the Green House® that there be one big table, because that's how - that makes a meal into a community experience." (PBS Lehrer NewsHour, 01/23/08).

Similar in organization to the Creekview households, ten private resident bedrooms surround a large semi -private living space called "The Hearth" which includes a fireplace, living room, dining table, and open kitchen. Residents are encouraged to participate in household activities including meal planning and preparation, clean up and other activities. As a self -contained house, all resident and staff support areas are provided (Figure 7).

Personal care services are provided by specially trained staff dedicated to each house, while nursing services are provided by visiting nurses who are responsible for multiple houses.

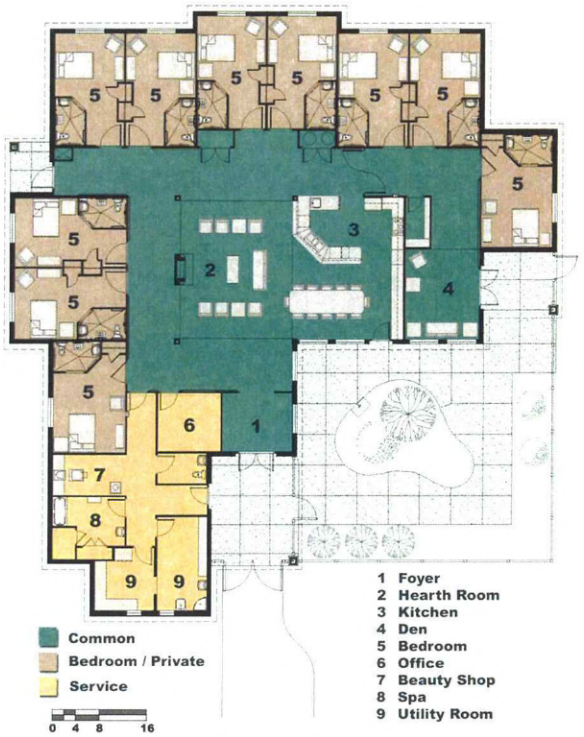


Figure 7

(DESIGN 2004)

Although the Green House® model envisions stand alone, self - sufficient homes, in practice, the first Green Houses® in Tupelo, Mississippi rely upon the support of the adjacent traditional nursing home for services such as hou sekeeping, central supplies and food purchasing, including some of the food preparation already accomplished (The Gerontologist, Vol. 46, No. 4, pg. 538).

Green House® Hearth Room looking toward kitchen
(DESIGN 2004)

Green House® Hearth
(DESIGN 2004)

While Creekview and the Green House ® demonstrate a household plan layout where private resident bedrooms open directly toward the semi-private living spaces, other organizational approaches are also in use. Household organizations that locate reside nt bedrooms along corridors used only for accessing the bedrooms can provide an environment more closely related to a single family home, where one typically finds bedrooms separated down a short hallway from living, dining and kitchen areas. This concept was used at Meadowlark Hills and can be seen in the Chapman Sha lom Home East nursing homes design currently under construction in Saint Paul, MN (Figure 8).

(Figure 8)

Within this alternative organization of the environment, the corridor serves as an additional transition zone between the semi - private living areas and the private bedrooms. It is important when using this organizational technique that entrance to the household from semi -public areas occurs f irst into the semi - private social areas of the household. As in our homes, the front door does not enter into the bedroom hallway.

Household Size

The scale of the environment is one of the most significant aspects to determine whether it is perceived as institutional or homelike in nature. In the case of the household model there are three major factors that influence the size and scale of the environment: the number of residents that make up the household grouping, the physical size of the environment, a nd the staff ratios necessary to provide the desired levels of care.

Recently constructed households tend to consist of between eight and twelve residents. This size of social grouping appears to be small enough to eliminate the potential disruption cause d by excessive numbers of social interactions associated with larger group size, while also providing the desired critical mass needed

to foster personal relationships. " In any group we tend to see one-third of residents who participate in all offered act ivities, one-third who almost never participate and on -third who may or may not join in" (Powell 1998)(bibliography -personal discussion during project meetings while designing PGC replacement facility). Using this observation, with a household size of 8 -12, between three and eight residents will be available as part of the social environment. This size of social group also provides enough diversity to assure some level of common interest within the group. This is important as it is highly unlikely that all residents of what are often random groupings of individuals, whose only commonality is their need for skilled nursing care, will be in harmony with what they *wish, think, and feel.*

The dimensional size of the physical environment should be matched to the activities and group size being accommodated. If the physical environment is too small, overcrowding occurs. Too large, and the group may be overwhelmed by the space, therefore losing the intimacy and comfort associated within residentially scaled environments. The influence of geometry cannot be underestimated as a factor in creating appropriate scaled environments. Resident bedroom spaces require a given area (approximately 13 feet by 20 feet), a means of access into the space and enough exterior wall for placement of a window. When arranging more than ten or twelve resident bedrooms in a plan, one of two things occurs. Either the social areas around which the bedrooms are arranged become oversized, or resident rooms must be located along corridors leading to and from the semi -private, social areas of the household. Shared bedrooms alter the geometry somewhat, as these rooms only require a single entry door and bathroom for two sleeping spaces. But use of shared rooms provides only marginal advantages in the geometry of the arrangement.

Examples of designs that are described as households or sometimes neighborhoods that accommodate from 16 to 24 residents are inconsistent with the concept of a true household. Primary groupings of living and dining areas for this magnitude of group size may be far better than the 40 -60 resident groupings they replace, but once the quantity of twelve residents is exceeded, it appears that the positive potential of the household model is diminished and confused. One exception h owever, may be in the case of short-term stay populations. This population group often is comprised of younger "patients" residing within a short -term stay

nursing home to receive intensive physical or occupational rehabilitation therapy after a hospital s tay. These patients have no desire or inclination to remain as residents of the facility. Short-term rehabilitation facilities offer a high -tech, high-touch environment reminiscent of a hotel or spa experience. In this situation, larger scale social areas and patient rooms located along corridors may be a reasonable response to a transient population concentrating upon "graduating" out of the program.

The third factor that influences household size is the ratio of direct care staff to the number of residen ts being served. Ideally, the residents of a household would be served by at least one dedicated resident assistant during each of the day, evening, and night shifts. Additional staff would then be added during the heavier care day and evening to assure th at residents receive the assistance needed. This can be a difficult balancing act since required assistance can vary considerably depending upon the acuity level of the residents being served, or even from one day to the next, as resident well being change s due to short term episodes of sickness.

Multiple households that are interconnected, have greater flexibility in either adding staff as needs increase, or reducing staff levels during the night shift when one assistant can cover multiple households under one roof. Adjustments in staffing levels are more difficult to achieve in the case of separate detached, Green House® or Small House models where staffing can never be reduced to less than one staff member per household.

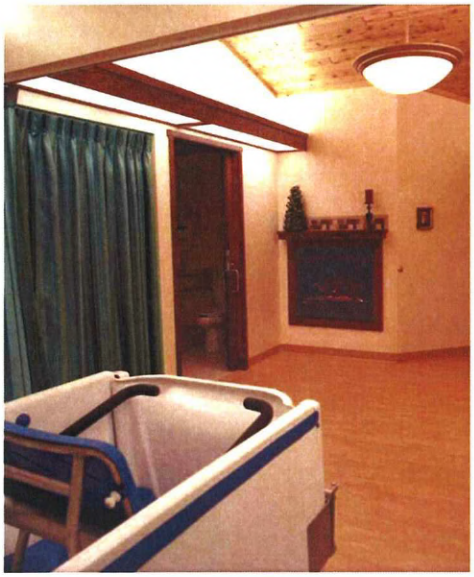
Flexibility for a Variety of Population Groups

Small clusters of residents within household scale environments provide the opportunity for operators to develop individual strategies in the grouping of resident populations. Some care providers may chose to group residents with similar "diagnoses" or care needs, together within homogenous household settings. This calls for specialized staff trained in particular interventions necessary to care for specialized populations. It may also enhance camaraderie among residents with similar backg rounds and experiences. Other reasons for homogenous grouping may be funding and referral advantages as in the case of the Green Houses ® of Chelsea, Massachusetts where plans call for houses identified by different populations including people with Lou Geh rig's Disease (ALS), AIDS, Hospice, or the most common special population group, those with Alzheimer's or other dementias.

Other care providers prefer to allow houses to fill organically with the intention that, over time, staffing requirements among houses may equalize as each house gains a heterogeneous population with a mix of heavy care and lighter care residents. This philosophy reinforces the concept of home in that, once a resident moves into a room, and becomes part of a household they can remain as long as desired without the need to move again.

Deinstitutionalize Clinical Resources

Providing a normal living environment requires intentionally working to eliminate, or re -envision the many clinical elements found within the traditional institution al setting. Even within smaller scale environments, the need remains for staff to complete tasks such as charting, distribution of medicine, processing soiled items, and bathing residents. Many examples of innovative, homelike solutions are currently in us e including the staff work area, medicine distribution cabinet and bathing room illustrated below.



Creekview – Medicine Island (foreground) and Staff Work Desk © Nelson•Tremain Partnership

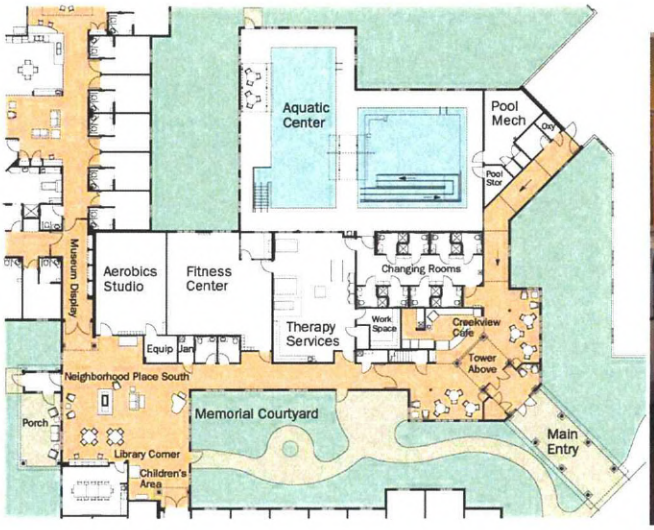
Creekview – Bathing Spa with Fireplace © Nelson•Tremain Partnership

The Neighborhood – Enabling Relationships within Community

The household models encompass the *private* and *semi-private* zones within the *hierarchy of space*. Yet in creating a quality of life that encompasses life in all its fullne ss it is necessary to maintain relationships with the greater community and culture. These types of relationships occur best within the *semi-public* and *public* realms.

We all need to get out of the house on occasion to meet with others and participate in a wider range of activities than may be available within our immediate "family group." In order to engineer one's life to maximize high *flow* activities (*Working, Studying, Driving, Hobbies, Sports, Movies, Talking, Socializing, and Sex*), a variety of oppor tunities must be reasonably available. Not all activities and personal encounters can be pre -planned. There is value in serendipity and chance meetings that require exposure to a larger community. A neighborhood center shared among several households also encourages participation from members of the greater community can serve this function. Large group activities, religious services, music, theater and fitness opportunities within easy access can be made available to residents. At Creekview at Evergreen Re tirement Community, a

fitness center including a warm water aquatic therapy center, providing memberships to community elders is located in the heart of the nursing home (Figure 9). By providing a hub of activity within the nursing home, residents' lives a re enhanced through greater opportunities, while at the same time demonstrating to the community that aging is a natural part of life and the nursing home is not the last place one would like to find oneself.



(Figure 9)

Creekview – Neighborhood Place South

Creekview – Neighborhood Place

Creekview – Aquatic Center

Creekview Café'

Household Models and the Regulatory Mi leau

Ten years elapsed between the initial conception of the household in 1987 and its realization with the opening of Creekview at Evergreen Retirement Community in 1997. This time lag resulted from a need to clearly understand the impacts that such a ra dical reworking of the nursing home would have on the physical, operational, and financial aspects of the sponsoring organization. It was also necessary to gain the support of regulatory agencies that, in their conceptual review, identified over 100 potent ial areas of regulatory conflict. With the assistance of a small -scale pilot project of eight beds within a portion of the existing nursing home, and some creative problem -solving by the entire team, including some helpful regulators, this list of conflict s was reduced to just a handful of issues that were able to be addressed without waivers.

This positive ending might cause one to believe that the creation of household model nursing homes is not impeded by regulations and that any organization should be able to replicate the process and outcomes pioneered by early household advocates. This however, is not the case. Even within a supportive State regulatory environment that enabled the creation of Creekview, subsequent Wisconsin projects encountered simila r difficulties. This can be attributed to the fact that no two projects or sponsors are identical, and that interpretations and "alternative methods" for compliance are always individual and specific in their application. Education and negotiation with cod e officials and regulators, often over seemingly small issues, must occur over and over again, one project after another.

During the past twenty years of working to create small -scale environments that enable a normal life of quality for nursing home residents, we have encountered a number of recurring issues. It is discouraging, having worked diligently to gain acceptance in one situation, to start over again in the next to gain favorable interpretations, receive waivers or be denied approval for nearly identical concepts and designs. The following is a review of recurring regulatory hurdles that are commonly encountered.

Overlapped, Confusing and Contradictory Regulatory Jurisdictions

An often heard complaint of facility operators and designers is that various regulatory agencies have overlapping and at times conflicting requirements. A single project may be required to comply with three or four separate regulations addressing the same issue. A common example is that facilities must meet the local building code requirements that protect occupants against a variety of life safety issues. Nursing homes are also required to comply with the NFPA 2000 Life Safety Code. On top of this, many state or local jurisdictions and their fire inspectors have adopted more recent editions of the NFPA Life Safety Code (either 2003 or 2006). State licensure regulations also have extensive requirements that cover many of the same life safety concerns. It is inevitable that the requirements from four separate regulations or standards will contain contradictory requirements, of which the design team is required to determine which is the most restrictive. Similar situations occur with requirements pertaining to food service operations, accessibility standards, and elevators, to name a few.

Several years ago the State of Wisconsin reorganized the method by which health care facility plan reviews and approvals are conducted. A process that formerly involved several jurisdictions including the state health department, fire marshal's office and building codes division was consolidated into a single review. All health care facility plan reviews within the State are now conducted solely by the health department. This provides a clear and direct jurisdictional responsibility. One signi ficant advantage to this situation is that in the case of conflicts between various codes and standards, facility operators and designers are no longer put into the situation of trying to mediate solutions between multiple bureaucracies. Conflicts and discrepancies are able to be solved by working within a single state agency.

Recommendation: States should be encouraged to develop methods whereby plan reviews for health care facilities are consolidated under a single entity in order to minimize redundant and overlapping requirements.

Interpretations Approved in Plan Review are not Recognized at Final Inspection

It is not unusual that during a final inspection survey, prior to occupancy, portions of the design that received approval or favorable interpretation during plan review, are found out of compliance by the survey team. This is the most costly time for compliance issues to be discovered and can lead to significant delays in people moving into their new home and compromises to the desired environmental outcome in addition to the financial costs.

In our practice, to alert owners to this potential, we have been required to include contract language within our owner/architect agreements that reads: " The Owner may request certain design elements that do not strictly comply with some regulations and codes. The Architect will work with the Owner to receive favorable interpretations, waivers, or variances of such requirements. Additionally, the Owner acknowledges that regulatory plan reviewer and field inspectors may interpret requirements differently leading to conflicting requirements that the Architect will endeavor to resolve in association with the Owner."

Facility operators and designers need to be given assurance that a plan approval actually has meaning.

Recommendation: States should be encouraged to maintain consistency in the interpretation of codes and regulations. This can be accomplished by requiring that Plan Reviewers and Final Inspectors are the same person. This will create a situation where the regulator has an interest in the final outcome and firsthand knowledge of issues covered during the plan approval process. Additionally, a mechanism for tracking and documenting interpretations (both positive and negative) would help maintain an institutional memory in case of staffing changes.

Kitchen Spaces Open to Corridors

An open floor plan that eliminates barriers, allows interconnection among spaces and easy access by residents, is one of the most critical features of the household model. Prior to the year 2000, providing spaces open to corridors was extremely difficult and required use of "suites of rooms," or the staffing of "nursing stations" on a 24-hour basis to provide direct supervision of the open spaces. Today, all model building codes have adopted language similar to that within the NFPA 101, Life

Safety Code, allowing spaces that are not used as sleeping areas, or for hazardous uses to be unlimited in size, provided appropriate fire suppression and smoke detection systems are installed.

Kitchens remain a difficult area of interpretation. *Cooking Facilities* are required to be protected in accordance with NFPA 96, using a commercial vent hood with specialty fire suppression systems (NFPA 101, LSC paragraph 9.2.3). An exception is allowed for "small appliances used for reheating, such as microwave ovens, hot plates, toasters and nourishment centers" that are exempt from "requirements for commercial cooking equipment" (NFPA 101, LSC paragraph A18.3.2.6).

The difficulty with these requirements occurs with the interpretation of what constitutes commercial equipment and the difference between cooking and reheating. Some jurisdictions allow the use of commercial, convection ovens for baking of bread and muffins, or even pizza. Others will not. Large "pannini grills" (a commercial size George Forman® grill) may be allowed to cook grilled cheese sandwiches, or pastrami on rye, while grilling a hamburger is not allowed. Is heating of a pre-cooked hot dog allowed, but not an uncooked sausage? The rationale for these requirements is that heating is different from cooking, especially in the case of foods that may produce "grease laden fumes." This is backed up by data that a large percentage of fires within nursing homes originate in kitchens, with *Confined cooking fires in kitchens* accounting for 24%; and *Kitchen or cooking areas* 19% of all nursing home fires (March 2006 NFPA Report "U.S. Fires in Selected Occupancies).

These statistics do not however, differentiate fires by size of kitchen or number of meals being produced. There is a quantitative and qualitative difference between a large commercial food service operation and a household kitchen producing family-sized meals.

In consideration of these differences, the Minnesota Department of Health (MDH) has developed a *Waiver for Neighborhood Kitchens*. Recognizing that flexibility in timing of the breakfast meal will improve the quality of life for residents with varying morning routines, this waiver was developed to allow cooking of breakfast within "neighborhood" size groups, using residential kitchen equipment. There are a number of requirements that must be met in

order to allow this waiver including: the kitchen serves 25 or fewer residents; breakfast preparation is only for those residen ts and staff in the neighborhood served by the kitchen; breakfasts are served sequentially, meaning that breakfast is served on the residents' schedule and that gathering of all residents at one time is not allowed; a residential range must be electric wit h key-operated disconnect switch; and a residential vent hood may be used that exhausts directly to the exterior provided meats that produce grease as they cook are p repared in a commercial kitchen . Other requirements, not related to fire safety also apply and will be discussed in a later section.

The MDH neighborhood kitchen waiver is an excellent *initial* response to this important issue, however, expansion of this concept to allow the cooking of lunch and dinner meals without stringent limitations on the types of food allowed to be cooked, needs to be addressed. Costly, commercial vent hoods required to comply with NFPA 96 are an impediment to the creation of normal homelike environments providing the activities and aroma of mealtime preparation. Strict a dherence to the current requirements may contribute little to the protection of resident life safety when less costly alternatives are available. A recent federal government workshop identified that a single sprinkler head in a residential kitchen would be an effective fire suppression measure, although the best situation is a fully sprinklered residence in accordance with NFPA 13D, 13R, or 13 (NIST Special Publication 1066, 2007). Nursing homes are already fully sprinklered, thus meeting this finding.

Recommendation: Research needs to be conducted to determine the actual life safety risks associated with cooking fires in small-scale operations. Alternatives to NFPA 96 standards for protection of cooking equipment must be allowed in the case of small-scale environments. It must be recognized that residential scale kitchens, fully protected by fire suppression systems provide adequate life safety without additional fire suppression measures. Similar alternative consideration must be made for small-scale operations including facility cafés and delis that serve limited menus for visitors, staff and residents.

Protection against Non-Fire Dangers in the Kitchen

In additional to fire safety, there are many regulations that are intended to protect residents aga inst perceived or real dangers in

the kitchen. These typically include protection against food borne illness or physical safety against injury.

National Sanitary Foundation International (NSFI) requirements provide specification of materials and equipment to reduce the spread of disease. Yet these requirements make no distinction between large and small food operations. Requirements within small-scale households for 6" sanitary legs on cabinets, and commercial refrigeration and dishwashing equipment , impinge on the residential nature of the environment, add ing significant cost without proven protection against risks. In the case of dishwashing equipment, there is no difference in sanitation between residential and commercial equipment as evidenced by tests conducted at Evergreen Retirement Community under the supervision of the Wisconsin State Department of Health. Other facilities using commercial equipment within household settings have found that dangers to residents actually increase with the addition of these unfamiliar hot surfaces and steam in the kitchen. True disinfection of surfaces only occurs at temperatures far higher than the 180 degrees required by NSFI.

Protection against physical harm typically includes requirements to secure noxious chemica ls, or dangerous items such as knives, and appliances. Anecdotal evidence indicates that, within a normal residential environment, residents retain an understanding of potential risks associated with many such dangers, and that safety measures built into f acilities are often not implemented once the facility opens.

Recogni zing the benefits of normal home environments, the *Waiver for Neighborhood Kitchens* in Minnesota also addresses these additional safety issues. Although Minnesota still requires commercia l dish washing equipment, residential style cabinets are allowed with NSFI laminate countertops and durable laminate interior surfaces, and breakfast foods may be stored in residential refrigerators overnight. The kitche n may also be used for activity prog rams. Though a key-operated disconnect for the range is required, use of the switch and securing of other items is not mandated. This waiver program is also recognized by the Minnesota Environmental Health Division, charged with food safety, which also all ows similar arrangements within assisted living and adult day facilities.

Recommendation: Exceptions to compliance with NSFI requirements should be provided for small-scale food preparation areas. State and local regulatory agencies should be encouraged to defer food service sanitary oversight to long-term care regulators who are more familiar with the needs of nursing home residents. Research needs to be conducted to determine the need for commercial food service requirements within small-scale operations.

Laundry Facilities

Many state health requirements mandate separation of soiled and clean processing areas within a laundry. In is unnecessary and impractical to provide separate processing areas within small household-scale environments. In these set tings there is less risk of cross contamination and infection and operational measures can be taken, such as washing individual resident clothing separately if needed. In Wisconsin, the personal laundry and soiled utility areas rooms are allowed within the same area, provided air flow is provided in the direction from clean to soiled. This is a reasonable approach to clean and soiled function s sharing a space without requiring separation by walls.

Recommendation: It should be made clear that in small-scale operations, separation of clean and soiled areas is not required.

Handrails

According to a CMS Survey & Certification letter (12/21/06), "The purpose of the handrail is to assist residents with ambulation and/or wheelchair navigation." The need for ha ndrails is clearly an artifact from the corridor -based model of facility design. In facilities with long corridors, residents are required to navigate the corridors in order to access activities of daily living not available within one's "private" bedroom, including dining and social activities. Within a household, the need for and desirability of handrails is significantly reduced, if not eliminated. Household corridors are an extension of the semi - private social spaces.

Requirements for handrails limit t he potential to fully utilize circulation spaces for meaningful and valuable activities. In some

configurations, resident bedrooms are literally "across the hall" from the country kitchen, and often only short distances must be traversed to access other ac tivities. Participation in daily activities is directly influenced by proximity and ease of access, and the intrinsic design of a household maximizes each, providing a significantly greater "mobility enhancer" than any handrail.

It is unreasonable to req uire handrails along "each side" of a corridor that separates spaces allowed to be open to the corridor for life safety purposes, thereby "fencing off" and limiting direct access to these spaces. This situation has occurred, and has been vigorously support ed by some state regulators.

Inclusion of furniture along walls of corridors can provide resting points for elders, thereby improving ambulation while enhancing hominess. Handrails interfere with use of wall space in this manner.

Recommendation: Handrails should be explicitly exempted from installation along spaces open to the corridor. Handrails should be allowed to be discontinuous to allow for furniture placement and other installations (e.g. display cases, artwork, etc.), that do not reduce the required width of egress. Alternatives to handrails, such as "lean rails" (plate rail design for stability) should be allowed.

Protrusions into the Corridor Width

There are conflicting requirements as to the allowable distance elements may protrude into the width of corridors. NFPA 101, LSC allows only 3 ½" protrusion, while the Americans with Disabilities Act Architectural Guidelines (ADAAG) allows 4" for items within 6'-8" of the floor level. Unfortunately many industries, such as lighting manufacturers ut ilize ADAAG standards in design and manufacture of products. Compliance with NFPA 101, LSC precludes the use of typical elements of home, including furniture, plants or wall mounted, sconce lighting fixtures.

Many CMS regional offices have interpreted th at the 3 ½" protrusion applies to all corridors, regardless of width, meaning that in the case of corridors that exceed minimum width

requirements, protrusions are still limited to 3 ½" even though the required exit width is maintained.

Recommendation: Protrusions within corridors greater than 3 ½" or 4" should be allowed within defined circumstances. Explicit allowance should be made for protrusions that are unlimited in dimension, provided the required exit width is not reduced in excess of a specified (4") distance.

Eight-Foot Corridor Width

There are only two provisions within the Life Safety Code that have nothing to do with life safety within health care occupancies. These are the requirements f or windows in resident rooms and the requirement for eight foot wide corridors. No one would promote the elimination of windows, but eight foot wide corridors are another matter. This requirement has been rationalized as the min imum width necessary to push beds or gurneys past each other. If this is the cas e, what happens in a fire emergency when two beds are blocking the fire exit at the end of the corridor? Emergency procedures do not include the transportation of residents in their beds. This requirement may have had a functional basis in the case of hosp itals but is costly and unneeded requirement in nursing homes.

Recommendation: Eliminate the requirement for eight foot corridors in nursing homes perhaps considering six feet instead.

Three Foot - Eight Inch Wide Administrative Office Doors

Regional CMS offices are requiring that door s to offices for administrator s, directors of nursing and social workers be 3' -8" wide and located on an eight foot wide corridor. This requirement is based upon the assumption that resident s must be provided access to the se important administrative personnel, while being transported in their bed. There are certainly more dignified, alternative methods for providing such access that do not require construction of excessively wide doors and office corridors.

Recommendation: CMS should make it clear that alternative and dignified means of access to administrative services are allowable without requirements for wide halls and doors.

Direct Line-of-Sight as Control over the Corridor

When staff members are assisting resident s and performing meaningful care tasks, they are most often wit hin the resident room or bath room, with no visual connection to public spaces. This need for visual control has been rationalized as providing quick assistance to a resident who may fall, yet m ost falls occur within private resident rooms. No one would suggest line -of-sight into all bathrooms. Requiring visual control is an outdated concept that does not recognize the realities of nursing care, nor the advances achieved through communication tec hnologies.

Recommendation: CMS should stipulate that a requirement for direct line-of-sight from staff work areas or "nursing stations" is not required within nursing facilities.

Distance to the "Nurses' Station"

Many state requirements include maximum travel distance from a nursing station to resident rooms. These requirements assume that a fixed nursing station is required for staff to perform their work and for electronic calls to be received. There are many approaches to resident care that do not ne cessitate a fixed location. The only requirement should be that adequate staffing levels be provided to meet the care needs of residents.

Recommendation: CMS should stipulate that no fixed location is required for nursing staff to care for residents.

Wired and Wireless Call Systems (UL 169)

Requirements that various alarms or notification be directed to a nurse station or other permanently staffed location does not recognize the reality that nursing staff do not remain in fixed locations. Technological advances in resident to staff communication systems that do not require the use of hard wired systems can provide superior performance, allowing resident

assistants and nursing staff to respond to resident calls from any location.

Recommendation: Consistent specifications for wireless call systems should be defined that eliminate the need for individual state regulators to evaluate the efficacy of multiple nurse call systems.

Security against Residents leaving Unescorted vs. Fire Safety

To address the issue of security against residents leaving the building unescorted, the State of Minnesota Department of Health, Department of Administration, and Office of the Fire Marshal met with designers and operators to devise a methodology by which health care facilities could secure areas of buildings through the use of magnetic locking devices with keypad controls. Locking of facilities was important not just in long-term care populations but also as a means to secure patients of hospitals against outside intrusion after a series of high profile abductions of newborns and gang related shootings. Minnesota's *Special Emergency Egress Control* required that magnetic locks must be interconnected to the fire alarm system, as well as, provide a manual control whereby nursing staff could release the lock in case of non-fire related emergencies. This process demonstrated the ability of several State agencies to work out a solution that met the needs of caregivers to protect patients and residents and to address the legitimate life safety concerns. This provision in the Minnesota state regulations worked alternative solutions to egress and security issues for a number of years. Unfortunately, regional CMS enforcement of the NFPA 2000 provision that *delayed egress devices* (NFPA 101, LSC 2000, Paragraph 7.2.1.6.1) are the only allowable means to secure exits, eliminated this well thought out option.

Recommendation: The risks surrounding security against intrusion or residents leaving unescorted are equally as legitimate as those for fire safety. It is unreasonable to believe that delayed egress hardware is the only safe method to secure a path of egress. Alternative methodologies such as Minnesota's Special Emergency Egress Control should be allowed.

Security for Outdoor Spaces

Access to the natural environment is an extremely important quality of life measure. Securing exterior yard space is difficult to achieve given the requirement that two egress controlled doors are not allowed (only one delayed egress device is permitte d) within a means of egress. It often is not possible to provide an area of refuge fifty feet from the exterior face of a structure. Alternatives must be made available that allow safe yet secure access to outdoor areas.

Recommendation: Yard spaces should be allowed to be independently secured with provisions for emergency egress in case of fire.

Smoke Compartment Requirements

Nursing home fire safety requirements are based upon a concept described as "defend in place." This concept recognizes that th e population groups served within these facilities may be incapable of independent exiting in an emergency due to reduced cognitive or physical capabilities. Therefore buildings are constructed using safety standards that are intended first, to limit the s pread of a fire from its origin and second, to allow movement of residents to another compartment of safety, on the same level within the building, eliminating the need for an exit. In the case of large facilities, this requirement would typically provide "smoke compartments" serving between twenty and sixty resident rooms. In the case of small facilities with open floor plans, the provision of separate smoke compartments may be difficult, without compromising the physical proximity of resident bedrooms to the semi-private social areas of the household. Most household scaled environments are far smaller (from 6,000 -12,000 square feet) than the allowable 22,500 square feet allowable within a smoke compartment (NFPA 101, LSC paragraph 18.3.7).

Recommendation: The requirement for subdivision of small-scale household environments into two separate smoke compartments should be evaluated as to its efficacy and impact on the living environment for residents.

Accessibility Standards

Accessibility standards as d efined by the Americans with Disabilities Architectural Gui delines (ADAAG) do recognize the fact the strength and stature of older people differs significantly from that of independently functioning disabled individuals. In the case of nursing environments , current ADAAG standards hinder the safe and effective care of people requiring assistance with activities of daily living as they require institutional grab bar configurations that are of little use, such as requiring grab bars located behind toilets.

Recommendation: Within care environments where residents are assisted with transfers, research should determine the optimal range, as opposed to extreme range, of use to determine the required size and location of grab bars. Extension of side grab bars from the back wall should be reduced to allow shorter, fold-down bars and rear wall grab bar requirements should be eliminated.

Sliding Doors in Low Occupancy Areas

Building codes have stepped backward by no longer allowing sliding doors in low occupancy sp aces such as resident bathrooms. Sliding doors provide superior utility in these situations by providing door operation that as easily within the ADAAG specified range of motion without the need to maneuver wheelchairs backwards in tight quarters. Sliding doors also have no "door swing," thus requiring less floor space. Many state health departments also preclude use of sliding doors.

Recommendation: Sliding doors must be explicitly allowed within all occupancy types within rooms serving low occupancy spaces.

Separation between Nursing Home and Daycare Occupancies

State licensure requirements often require a two -hour occupancy separation between nursing home and daycare (either child or adult) occupancies. Significant benefits are gained by the provision of opportunities for intergenerational activities within long term care environments. This requirement does not seem

reasonable particularly in the case where the daycare meets the same construction classification a s the adjoining nursing home.

Recommendation: Intergeneration programming should be encouraged to the greatest extent possible by allowing programs to co-exist under one roof.

Allowance for Use of Personal Furniture

CAL 133 is a flammability standard for upholstered furniture that has been adopted in many jurisdictions. This standard was developed to limit the fuel load within certain public occupancies including nursing homes. The original standard was developed with an exception for occupancies that are protected by a fire protection system. This exception has been eliminated or severely restricted in many jurisdictions. For example, the Minnesota Fire Marshal promulgated rules that limit residents to one piece of upholstered furniture, within their own bedroom, that does not meet commercial furniture standards. This is a restriction that limits resident rights based upon overzealous fire officials ' individual determination of risk. Asbestos was once used in the name of fire safety, now the fire retardant chemicals used for several decades are being linked to cancer deaths and California is attempting to outlaws their use (www.latimes.com/news/local/la - me-couches7mar07,1,3742510.story). Where are the grea ter risks?

Recommendation: It must be made clear that resident rights to use their own furniture should not be limited within fire sprinklered buildings.

Standards for Small-scale Environments

By definition, a nursing home is "A building or portion o f a building used on a 24 -hour basis for the housing and nursing care of *four* or more persons who, because of mental or physical incapacity, might be unable to provide for their own needs and safety without the assistance of another person" (Paragraph 3.3.132, NFPA 101 LSC 2000).

Four residents is an extremely low threshold when 16 is common within other occupancy types. It needs to be recognized, as it is within other occupancy classifications such as Board and Lodging, that the level of risk in small fac ilities is not as great as in larger facilities and that different requirements are reasonable.

Recommendation: Separate Life Safety and Building Codes must be developed to provide appropriate but less stringent requirements than those currently allowed for small-scale environments.

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UNIVERSITY of MARYLAND
MEDICAL CENTER
MIDTOWN CAMPUS

827 Linden Avenue
Baltimore, MD 21201
410-225-8000
umm.edu/midtown

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

May 19, 2015

Re: Baltimore Nursing and Rehabilitation, LLC Certificate of Need in Baltimore City

To whom it may concern:

I am Brian G. Bailey, Senior Vice President and Executive Director of the University of Maryland Medical Center Midtown Campus ("UMMC Midtown"). UMMC Midtown provides a full range of community-based healthcare through more than 120,000 patient encounters each year in downtown Baltimore.

I am writing to express my strong support for the proposed construction of a new comprehensive care facility currently expected 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 to develop a truly novel approach to help avoiding hospitalizations and lowering hospital re-admissions via a state of the art post-acute care center.

I believe this collaboration and integration envisioned between the new facility and the UMMC Midtown Campus will not only be unique to Baltimore City, but also the state, and will advance our work to help support the Maryland Medicare Waiver.

Respectfully Submitted,

Brian G. Bailey

cc: Dr. Scott Rifkin, Mid-Atlantic Health Care, LLC

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Insights

CMS Raises Stakes With "Next Generation" ACO

By Matthew P. Amodeo

CMS has announced a new accountable care organization (ACO) demonstration model called the Next Generation ACO ("NGACO"), which will be implemented through CMS' Center for Medicare and Medicaid Innovation (CMMI). The NGACO model involves significantly higher risk levels than under the current Medicare Shared Savings Program (MSSP) and CMMI's Pioneer ACO program. The program is targeted at ACOs with significant experience in population health management and risk assumption. CMS anticipates approximately 15-20 NGACOs will be approved for the program. Many of the NGACO program details have yet to be disclosed, however, CMS has indicated they will be included in the Model Participation Agreement between CMS and participating ACOs. Some of the key NGACO program features are described below.

NGACO Key Design Elements

The NGACO program builds upon existing MSSP and Pioneer design elements, but includes four significant new features:

1. Greater financial risks and rewards;

2. Flexible payment options;

3. More opportunities for provider and Medicare beneficiary engagement and care coordination across the health care continuum; and

4. More accurate and predictable financial targets to encourage greater interest in full risk assumption.

Greater Financial Risks/Rewards

Shared Risk and Full Risk Options. NGACOs will have the option of choosing between two risk arrangements—shared risk or full risk. Under the shared risk option, during the first three participation years (PYs) the ACO's share of PY savings/losses will be 80 percent. During PYs 4 and 5 the ACO's allocable share of savings/losses will increase to 85 percent. Under the full risk option, the ACO's share of any savings/losses will be 100 percent. The ACO's share of savings and losses under both options is capped at 15 percent of the ACO's cost target (Benchmark). NGACOs will not be responsible for any Part D (drug) costs.

Flexible Payment Mechanisms. Under both risk sharing options, ACOs will have the ability to choose between four payment mechanisms. The payment mechanisms are designed to provide interim, ongoing financial support of ACO infrastructure operations, and to allow ACOs greater flexibility in structuring reimbursement arrangements with ACO providers, e.g., subcapitation. As noted above, regardless of the payment mechanism selected by the ACO, the ACO's share of savings/losses will be 80 percent/85 percent or 100 percent (depending on which option), subject to 15 percent cap.

- *Normal Fee-For-Service*. Providers in NGACOs that choose conventional fee-for-service reimbursement mechanism will continue to be paid directly by CMS at normal fee-for-service rates.

- *Fee-For-Service With ACO Support Payment.* Providers in ACOs electing this option will continue to be paid by CMS at normal fee-for-service rates, but the ACO will also receive an additional per beneficiary/per month (PBPM) payment of up to $6 PBPM to provide financial support for ongoing ACO infrastructure and operations costs. The ACO will be responsible for reimbursing CMS the total amount of the PBPM support payment at the end of the PY, regardless of any ACO surplus/deficit. The aggregate PBPM payment will be netted against the ACO's share of any savings. If the ACO generates a loss, it must pay CMS its allocable share of the loss (80 percent/85 percent), and repay the aggregate PBPM payments. ACOs electing this option will be required to provide significantly higher guarantees to ensure repayment of the support payments to CMS.

- *Population Based Payments (PBP).* This option represents a combination of both conventional fee-for-service reimbursement to ACO Providers/Suppliers, and interim PBPM payments to the ACO. As with the PBPM payment model, the PBP payment is designed to support ongoing ACO activities and provide flexibility in ACO provider reimbursement methods. Under this option, the ACO will specify a discount ,which CMS will apply to all claims submitted by ACO contracted Providers/Suppliers who have agreed to accept the discount. The ACO is free to determine the amount

of the discount, and may apply different discounts to different subsets of ACO Providers/Suppliers. CMS will apply the discount determined by the ACO to ACO Provider's/Supplier's claims payments. CMS will, in turn, pay the ACO a PBPM payment (PBP) equal to the ACO-selected discount rate multiplied by the projected (using the ACO's Benchmark) claims costs for services expected to be provided by ACO Providers/Suppliers to ACO-attributed beneficiaries. CMS reserves the right to adjust the PBP payment periodically to mitigate projected overpayments. At the end of the PY, CMS will reconcile the aggregate amount of the PBP payments against the actual aggregate amount of the discount off ACO Providers'/Suppliers' claims payments. If the aggregate PBP payments exceed the aggregate discount, the ACO must refund the difference to CMS. Conversely, if the aggregate PBP payments are less than the aggregate discount, CMS must pay the ACO the difference. The PBP and discount amount reflect only claims submitted by ACO-contracted Providers/Suppliers, not claims for services provided by providers who are outside the ACO (non-ACO Providers/Suppliers). The shared savings/loss reconciliation will be performed separately.

- *Capitation.* Beginning in an NGACO's PY2, it may elect to be paid under a capitation model. Under this option, CMS will use the NGACO's Benchmark to calculate a PBPM capitation payment equal to the projected cost of all services provided to ACO-attributed beneficiaries by both ACO Providers/Suppliers, and non-ACO Providers/Suppliers who have agreed to be paid by the ACO on a capitated basis (see discussion of Capitation Affiliates below). CMS will retain a withhold to secure payment of claims submitted by non-ACO Providers/Suppliers and non-Capitation Affiliates. The ACO is responsible to pay for all services provided by ACO Providers/Suppliers and Capitation Affiliates out of the PBPM capitation payments, though these providers will continue to submit "dummy" claims to CMS. At the end of the PY, CMS will reconcile the withhold retained by CMS against the aggregate claims costs for non-ACO Providers/Suppliers and non-Capitation Affiliate providers. If these claims costs exceed the withhold amount, the ACO must remit the difference to CMS, and vice versa. Reconciliation of Benchmark spending and application of the 15 percent cap to any savings/loss will be performed separately.

Opportunities for Enhanced Provider and Beneficiary Engagement

The NGACO program includes new design elements that allow ACOs to align with non-ACO providers in coordinating beneficiary care in ways not contemplated under the current MSSP and Pioneer programs. The NGACO program also includes incentives which encourage attributed beneficiaries to receive treatment from NGACO-affiliated providers.

- *NGACO Preferred Providers and Affiliates.* Under the existing MSSP and Pioneer models, ACOs are responsible (to the extent of the applicable risk sharing model) for the cost of care provided by providers both inside (ACO Providers/Suppliers) and outside the ACO. ACO Providers/Suppliers must generally agree to abide by the ACO's care management and coordination policies and procedures, while non-ACO Providers/Suppliers generally are not required to do so. Since beneficiaries have freedom of choice to seek care from any provider (whether in or outside of the ACO), ACOs have little control over claims costs for non-ACO Providers/Suppliers. Under the NGACO model, CMS has created two new "classes" of providers that can affiliate with one or more NGACOs in ways that will allow the ACO to better coordinate beneficiary care and control costs of the non-ACO Providers/Suppliers. These providers are called "Preferred Providers" and "Affiliates". Neither Preferred Providers nor Affiliates are considered for attribution purposes and therefore can participate in multiple NGACOs simultaneously. These new classes of providers also give ACOs greater flexibility in the types of payment arrangements they can have with providers, including downloading financial risk through subcapitation arrangements.

Preferred Providers are providers outside the ACO (*i.e.*, non-ACO Providers/Suppliers) who have agreed (verbally or in writing) to support the ACO's mission of care coordination and high-quality care for beneficiaries. Under certain circumstances, Preferred Providers may be eligible to provide new benefit enhancements authorized under the NGACO program (see discussion below) to ACO beneficiaries. Preferred Providers may also be Capitation Affiliates and/or Skilled Nursing Facility (SNF) Affiliates (discussed below), but in each case would be required to have a written agreement with the NGACO.

There are two types of NGACO Affiliates — Capitation Affiliates and SNF Affiliates. Both types of Affiliates must have written contracts with the ACO. Capitation Affiliates agree to accept payment for their services from NGACOs participating in the capitation payment mechanism. SNF Affiliates are SNFs which have agreed in writing to accept patients referred by NGACO Providers/Suppliers, Preferred Providers, and Capitation Affiliates.

- *Beneficiary Engagement.* A key element in controlling ACO health care expenditures is the engagement of patients in making important health care treatment decisions and living healthier lifestyles. The NGACO program includes several elements designed to encourage greater ACO beneficiary engagement in the delivery of their care.
    - *Beneficiary Reward.* NGACO attributed beneficiaries are eligible to receive cash payments from CMS if they receive a certain percentage of their care from ACO Providers/Suppliers, Preferred Providers

and/or Affiliates. CMS indicated that a semi-annual payment of $25 will be available to ACO beneficiaries if they receive at least 50 percent of their patient encounters from an ACO entity during each six-month period; however, CMS has not yet finalized these amounts.

- *Voluntary Alignment.* Beneficiary attribution under both the MSSP and Pioneer programs are claims-based models. That is, beneficiaries are aligned to MSSP/Pioneer ACOs on the basis of the amount of care they receive from an ACO Provider/Supplier. Beneficiaries are generally attributed to an MSSP/Pioneer ACO if the beneficiary received the plurality of his/her care from an ACO primary care provider. The NGACO model introduces a new beneficiary "self-alignment" option, which allows beneficiaries to self-align to an ACO by declaring alignment to a particular ACO Provider/Supplier. A beneficiary's self-alignment to an ACO will supersede claims-based attribution, even if a beneficiary did not receive the plurality of his/her care from a provider in the ACO.

- Enhanced Benefits. The NGACO program waives certain Medicare reimbursement restrictions on certain SNF, telehealth and post-discharge home care services for ACO attributed beneficiaries. The waivers are intended to encourage the coordination of patient care at important care transition points, as well as enhance the availability of certain services to patients who would otherwise not be entitled to them under existing Medicare payment rules. The SNF waiver waives the requirement for a three-day inpatient stay as a condition for payment for SNF services. In order to qualify for the waiver, the SNF must be a contracted NGACO SNF Affiliate, and the patient must have been referred to the SNF by an NGACO Provider/Supplier, Preferred Provider or Affiliate. The post-discharge home care benefit enhancement allows ACO beneficiaries to be covered for certain post-discharge (from inpatient facilities) home health services by lowering the supervision requirement under existing Medicare incident-to rules from "direct" to "general" supervision. The relaxed supervision requirement should help contain costs by increasing the volume of home-based services, which are generally less expensive than those provided in a facility. Under the telehealth services enhanced benefit, certain telehealth services will be eligible for reimbursement even if they do not meet the "rural" location requirements under existing Medicare payment rules.

More Accurate and Stable Benchmarks

A major criticism by many ACOs participating in the MSSP and Pioneer models is that fluctuations in the ACO's attributable population and cost Benchmark during the course of the PY make it difficult for the ACO to accurately predict financial outcomes. This lack of predictability has discouraged some ACOs from participating in the MSSP's current Track 2 and other downside risk options. Another common criticism of the MSSP is that the Benchmark formula calculations for these programs make it difficult for ACOs to realize year-over-year savings once significant savings have been wrung from care costs, and that they provide little upside potential for ACOs that are already cost efficient at managing populations.

To address these concerns the NGACO model introduces refinements and adjustments to the ACO Benchmark calculations and procedures currently being used under the MSSP and Pioneer models. NGACOs will still recognize savings to the extent they can improve year-to-year results as compared to the NGACO's historical expenses; however, the new Benchmark refinements will help level the playing field for more efficient ACOs by normalizing, based on the ACO's relative efficiency, the range of improvement required in order for the ACO to achieve savings. This should encourage more efficient ACOs and those accustomed to risk-based compensation to participate in the NGACO program.

The Benchmark procedures and adjustments described below will apply during PYs 1-3 of the NGACO program. For PYs 4-5 CMS intends to use different Benchmark procedures. NGACOs that want to continue in the NGACO program for the two additional PYs will enter into new participation agreements with CMS reflecting any new terms for continued participation.

- *Prospective Benchmark (one- year historical spending).* The NGACO program will feature a prospectively set Benchmark model. Under this model the NGACO's Benchmark is finalized at the beginning of the PY using the prior year's claims data. In contrast, under the MSSP and Pioneer models, the Benchmark is not finalized until the end of the PY, using up to three years of prior claims history. Proponents of the prospective Benchmark model maintain that the ACO is better able to manage its population and control costs if the ACO's Benchmark is fixed at the beginning of the PY, and the ACO knows, in advance, those members of its attributed population who are high-risk and in need of prompt care coordination/management in order to contain costs.

- *Risk Adjustment (3 percent corridor).* Risk scores and adjustments account for variations in the acuity of an ACO's attributed population over time, and ensure that the ACO's Benchmark accurately reflects the health status of its attributed population in any given PY. A higher risk score results in an upward adjustment to an ACO's Benchmark, and vice versa. As with MSSP and Pioneer ACOs, an NGACO's Benchmark will be risk adjusted annually using CMS' Hierarchical Condition Category (HCC) risk scores. Unlike the MSSP and Pioneer programs, the NGACO's full HCC risk score will be used to adjust the Benchmark for all attributed members, rather than just discreet components of the HCC score. In addition, an NGACO's HCC risk score will be allowed to increase by up to 3 percent annually, and will be subject to a 3 percent maximum reduction.

- *Discount.* The NGACO model introduces an additional ("discount") adjustment to the ACO's Benchmark. The discount is designed to account for the ACO's relative efficiency and quality performance in relation to other

ACOs, and Medicare regional and national fee-for-service expenditures. The discount will replace the Minimum Savings Rate savings threshold used in the MSSP and Pioneer Models. The discount adjustment will be comprised of three components — a quality score, and both regional and national efficiency scores. The combination of all three scores creates a discount range of 0.5 percent - 4.5 percent, which is applied to the ACO's trended and adjusted Benchmark. Application of the discount to ACOs whose trended and risk adjusted baseline Benchmarks are already comparatively low (due to the ACO's relative efficiency in managing its population costs), will increase the magnitude of the ACO's potential savings.

Key Dates and Terms:

Deadlines:

Notice of Intent (NOI) Deadline for Round 1 Agreement: **May 1, 2015**. NOIs are non-binding and do not compel the ACO to file an application. However, ACOs that do not file an NOI by May 1, 2015, cannot apply for participation in Round 1.

Application Deadline for Round 1: **June 1, 2015.**

Application Deadline for Round 2: **June 1, 2016**

Agreement Term:

Each Round will have an initial term of three (3) years, and a two-year renewal option.

Note: Given the short turn-around time between CMS' announcement of the NGACO program (Mid-March), and the NOI and Application deadlines, CMS is not requiring applicants to have entities formed or have any required state licenses until after the entity's application is accepted, but before the Participation Agreement with CMS is signed.

Please contact Matthew Amodeo in the Health Care Group of Drinker Biddle& Reath if you have any questions regarding this memo or the NGACO program generally.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Next Generation ACO Model

Model Overview Presentation

March 17, 2015

Agenda

- **Model Overview**
  - **Principles, Scope, and General Approach**
- Financial Model
  - Benchmark
  - Risk Arrangements
  - Payment Mechanisms
- ACO Entities
  - Next Generation Providers/Suppliers, Preferred Providers, and Affiliates
  - Program Overlap
- Beneficiary Engagement
  - Alignment
  - Voluntary Alignment
  - Benefit Enhancements
- Program Reporting
  - Quality
  - Monitoring and Compliance
  - Data Sharing and Reports
- Evaluation
- Learning System

Next Generation ACO Model

- Authorized under Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act) that established the Center for Medicare and Medicaid Innovation (CMMI) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care.
- A new opportunity in accountable care:
  - More predictable financial targets;
  - Greater opportunities to coordinate care;
  - High quality standards consistent with other Medicare programs and models.
- The Model seeks to test how strong financial incentives for ACOs can improve health outcomes and reduce growth in expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

Model Principles

- Protect Medicare FFS beneficiaries' freedom of choice;
- Create a financial model with long-term sustainability;
- Use a prospectively-set benchmark that:
  - Rewards quality;
  - Rewards both attainment of and improvement in efficiency; and
  - Ultimately transitions away from updating benchmarks based on ACO's recent expenditures;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care;
- Allow beneficiaries a choice to remain aligned to the ACO;
  - Mitigates fluctuations in aligned beneficiary populations
  - Respects beneficiary preferences;
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.

Model Scope

- 15 to 20 ACOs
- Representation from a variety of provider organization types and geographic regions.
- Minimum aligned beneficiaries: 10,000 (7,500 for rural ACOs).
- Two opportunities to apply:
  - First application due June 1, 2015 for January 1, 2016 start date
  - Second application due June 1, 2016 for January 1, 2017 start date.

Duration of Agreement

- First cycle ACOs:
  - *Three* initial 12-month performance years.
  - First performance year: January 1, 2016 – December 31, 2016.
- Second cycle ACOs
  - *Two* initial 12-month performance years.
  - First performance year: January 1, 2017 – December 31, 2017.
- Following initial performance years, all ACOs have potential for *two* 12-month extensions (calendar years 2019 and 2020).

Financial Model

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Financial Goals and Opportunities

Goals:

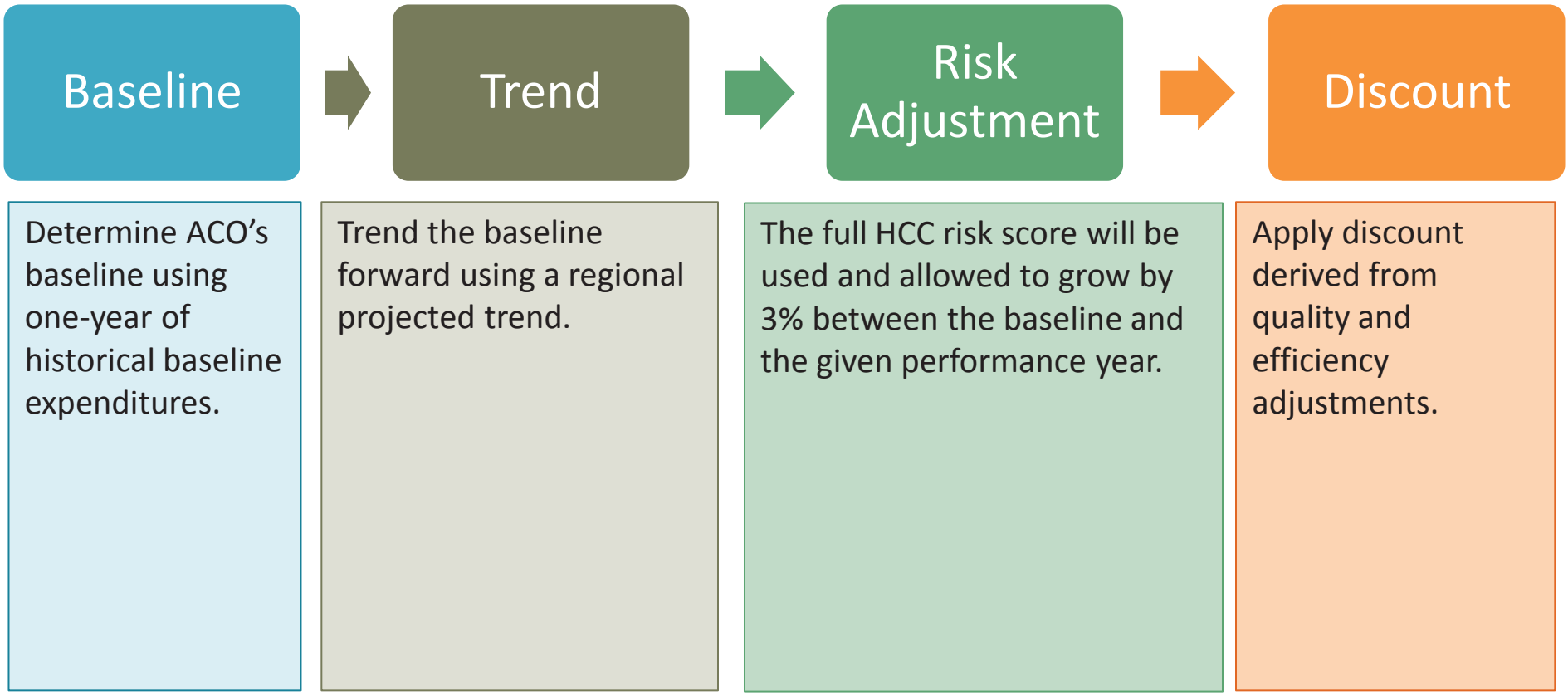
- Increased ACO financial risk;
- Long-term fiscal sustainability;
- Benchmark predictability and stability.

ACO Opportunities:

1) Greater financial risk coupled with a greater portion of savings;
2) Flexible payment options that support ACO investments in care improvement infrastructure to provide high quality care to patients.

Prospective Benchmark (2016-2018)

The Benchmark will be prospectively set prior to the performance year using the following four steps:



Trend (2016-2018)

The baseline will be trended forward using a regional projected trend:

- National projected trend similar to that currently used in Medicare Advantage (MA).
- Regional prices applied to the national trend.
- Under limited circumstances, CMS may adjust the trend in response to payment changes with substantial expected impact (negative or positive) on ACO expenditures.

Risk Adjustment (2016-2018)

- The Next Generation ACO benchmark is cross-sectional:
  - Alignment algorithm applied separately to baseline year and performance year;
  - Populations in these two time periods may be different.
- Prospective CMS Hierarchical Condition Category (HCC) risk scores will be applied to both baseline and performance year populations.
- ACO's full HCC risk score will be allowed to grow with a 3% cap (performance year compared to the baseline). Decrease in HCC risk score will also be capped at 3%.

Discount (2016-2018)

- Once the baseline has been calculated, trended, and risk-adjusted, CMS will apply a discount.
- Summing the following components creates each ACO's discount:
  - Quality:
    - Range: **2.0% to 3.0%**
    - Formula: [2.0 + (1- quality score)]%
  - Regional Efficiency:
    - Range: **-1% to 1%**
    - Compares the ACO's risk-adjusted historical per capita baseline to a risk-adjusted regional FFS per capita baseline.
  - National Efficiency:
    - Range: **-0.5% to 0.5%**
    - Compares the risk-adjusted regional FFS baseline to risk-adjusted national FFS per capita spending.
- Total discount range: **0.5% to 4.5%**

Alternative Benchmark Methodology (2019-2020)

- Principles for alternative benchmark methodology :
  - Eliminate or further de-emphasize the role of recent ACO cost experience when updating the baseline;
  - Take into account public comments received in response to the Shared Savings Program Notice of Public Rulemaking (NPRM) on alternative benchmark approaches;
  - Shift to valuing attainment more heavily than year-over-year improvement;
  - Consider the use of a normative trend;
  - Continue to refine risk adjustment for beneficiary characteristics that balances changes in disease burden against more complete coding;
  - Consider adjustments reflecting geographic differences in utilization or price changes.
- CMS intends to provide additional detail by the end of 2017.

Risk Arrangements

Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Parts A and B Shared Risk • 80% sharing rate (PY1-3, 2016-2018) • 85% sharing rate (PY4-5, 2019-2020) • 15% savings/losses cap • Discount	100% Risk for Parts A and B • 15% savings/losses cap • Discount

- Benchmarks calculated the same way for both arrangements.
- Different sharing rates affect ACO risk.
- For both arrangements, individual beneficiary expenditures capped at the 99th percentile of expenditures to moderate outlier effects.

Payment Mechanisms

Payment Mechanism 1: Normal FFS	Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payment	Payment Mechanism 3: Population-Based Payments (PBP)	Payment Mechanism 4: Capitation (2017)
Medicare payment through usual FFS process.	Medicare payment through usual FFS process plus additional PBPM payment to ACO.	Medicare payment redistributed through reduced FFS and PBPM payment to ACO.	Medicare payment through capitation; ACO responsible for paying ACO Provider/Supplier and Capitation Affiliate claims

- Goals of payment mechanisms:
  - Offer ACOs the opportunity for stable and predictable cash flow; and
  - Facilitate investment in infrastructure and care coordination.
- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures.

Infrastructure Payments

- All claims paid through normal FFS reimbursement.
- The ACO chooses an additional per-beneficiary per-month (PBPM) payment unrelated to claims.
- Maximum payment rate: $6 PBPM
- All infrastructure payments will be recouped in full from the ACO during reconciliation regardless of savings or losses.
- Sufficiently large financial guarantee required to assure repayments to CMS.

Population Based Payments (PBP)

- ACO determines a percentage reduction to the base FFS payments of its ACO Providers/Suppliers.
- ACO may opt to apply a different percentage reduction to different subsets of its ACO Providers/Suppliers.
- ACO Providers/Suppliers participating in PBP must agree in writing to the percentage reduction.
- CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments.

Capitation (available in 2017)

- CMS will estimate total annual expenditures for Next Generation Beneficiaries and pay that projected amount to the ACO in a PBPM payment.
- Some money withheld to cover anticipated care by non-ACO providers and suppliers.
- ACO responsible for paying claims for its Providers/Suppliers and Capitation Affiliates.
- Claims process:
  - All providers and suppliers submit claims to CMS as normal
  - CMS sends ACOs claims information for those services
  - ACO responsible for making payments.
- CMS will continue to pay normal FFS claims for care furnished to Next Generation Beneficiaries by providers and suppliers not covered by a Next Generation capitation agreement.

Financial Reconciliation

- Savings or losses determined by comparing total Parts A and B spending for aligned beneficiaries to the benchmark.
  - Individual expenditures capped at the 99th percentile.
- Risk arrangement determines ACO's share of savings or losses.
- Annual savings payment or losses recoupment occurs following a year-end financial reconciliation.
- Additional accounting for monthly payments that occurred during the performance year through PBP, infrastructure payments, or capitation.
  - May result in monies owed from CMS to the ACO, or vice versa.

Financial Guarantees

- ACOs required to have in place a financial guarantee sufficient to cover potential losses.
- ACOs participating in infrastructure payments required to have a larger financial guarantee.
- ACOs required to comply with all applicable state laws and regulations regarding provider-based risk-bearing entities.

ACO Entities

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Eligible Providers/Suppliers

- Next Generation ACOs may be formed by Medicare-enrolled providers and/or suppliers structured as:
  - Physicians or other practitioners in group practice arrangements
  - Networks of individual practices of physicians or other practitioners
  - Hospitals employing physicians or other practitioners
  - Partnerships or joint venture arrangements between hospitals and physicians or other practitioners
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health Clinics (RHCs)
  - Critical Access Hospitals (CAHs)
- Any other Medicare-enrolled providers/suppliers may participate in an ACO formed by one or more of the entities listed above.

Next Generation Preferred Providers

- Goal: Contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO:
  - ACO-selected set of partners to contribute to ACO goals;
  - May offer an ACO's benefit enhancements to aligned beneficiaries;
  - Services delivered to Next Generation Beneficiaries count toward the coordinated care reward calculation (direct payments made to beneficiaries by CMS);
  - Preferred Providers will NOT be associated with beneficiary alignment or used for quality reporting by the ACO;
  - Preferred Providers may also be Affiliates in order to participate in the capitation payment mechanism or the SNF 3-Day Rule waiver.

Next Generation Affiliates

- Two types of ACO partner entities associated with specific Next Generation design elements:
  - Capitation Affiliates
  - SNF Affiliates
- Goal: extend and advance ACO cost and quality goals.
- Affiliate care counts toward the coordinated care reward calculation.
- Preferred Providers may also be Affiliates.

Types of Next Generation Entities and Associated Functions[1]

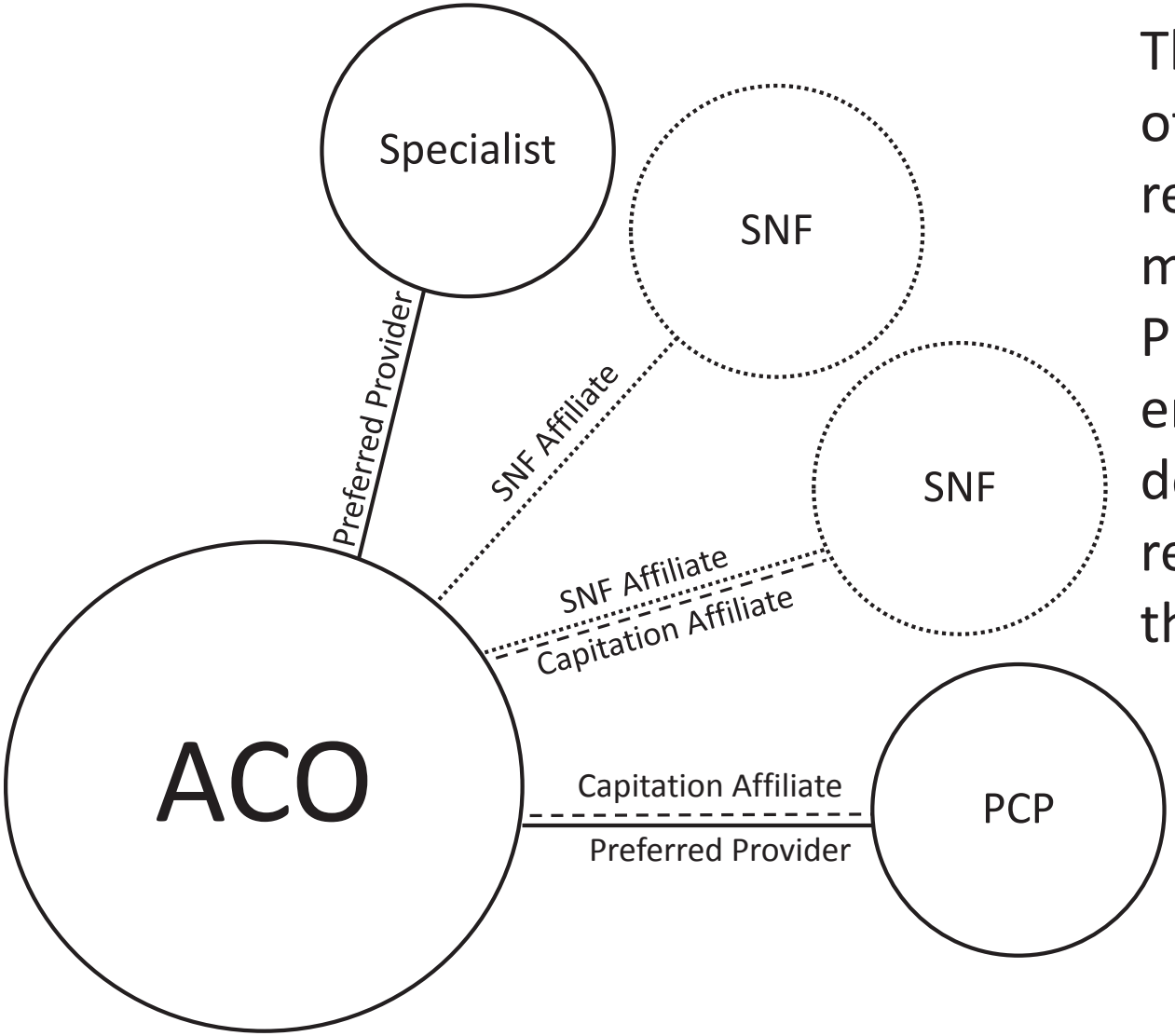
	Alignment	Quality Reporting Through ACO	Population-Based Payments	Capitation	Coordinated Care Reward	3-Day SNF Rule[3]	Telehealth	Post-Discharge Home Visit
Provider/ Supplier[2]	●	●	●	●	●	●	●	●
Preferred Provider					●	●	●	●
SNF Affiliate					●	●		
Capitation Affiliate				●	●			

[1] This table is a simplified depiction of key design elements with respect to provider and supplier roles. It does not necessarily imply that this list of capabilities is exhaustive with regards to possible ACO relationships and activities.

[2] Providers/Suppliers may NOT also be any of the other three entity types. However, Preferred Providers, Capitation Affiliates, and SNF Affiliates are not mutually exclusive with respect to each other. For instance, a Preferred Provider may also be a Capitation Affiliate but not a Provider/Supplier.

[3] There are two distinct roles involved in the 3-Day SNF Rule benefit enhancement: (1) admitting practitioners; and (2) SNFs. Admitting practitioners must either be Next Generation Providers/Suppliers or Preferred Providers. SNFs may be Next Generation Providers/Suppliers or SNF Affiliates. More information on the benefit enhancement may be found in Section VI.C.2. of the RFA.

Examples of ACO Relationships



This is a sample of some of the many possible relationships an ACO may have with non-Provider/Supplier entities. Each line depicts one type of relationship between the entity and the ACO.

Program Overlap

- **With other Medicare models and programs:**
  - Participation in other demonstrations or models generally *allowed*;
  - Next Generation ACOs *NOT allowed* to simultaneously participate in other Medicare shared savings initiatives (e.g., Shared Savings Program, Pioneer ACO Model)
  - Next Generation Provider/Supplier TINs *may not* overlap with Shared Savings Program TINs.
  - Preferred Provider and Affiliate TINs *may* overlap with Shared Savings Program TINs.
- **Within the Model:**
  - Primary care providers may be Providers/Suppliers in only one Next Generation ACO.
  - Specialists may be Providers/Suppliers in more than one Next Generation ACO.
  - Preferred Providers and Affiliates are not required to be exclusive to any one Next Generation ACO.

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Beneficiary Engagement Overview

- Encourage greater care coordination and closer care relationships between the ACO and beneficiaries:
  - Supporting meaningful discussions and considerations about care through the voluntary alignment process.
  - Enhancing services beneficiaries can receive from ACOs.
  - Offering a coordinated care reward directly from CMS for beneficiaries seeking care from Next Generation Providers/Suppliers, Preferred Providers, and Affiliates

Beneficiary Alignment

- Two-stage alignment methodology to prospectively align beneficiaries
  - No change from Pioneer Model methodology;
  - Based on plurality of evaluation and management (E&M) services.
- Stage 1: Assess percentage of each beneficiary's outpatient E&M services delivered by Next Generation Providers/Suppliers in select primary care specialties. Beneficiaries with such ACO services comprising a plurality of their total care will be aligned to the ACO for the subsequent year.
- Stage 2: For beneficiaries with less than 10 percent of their E&M services delivered by Next Generation ACO primary care providers, alignment may be based on E&M services provided by practitioners with certain non-primary care specialties.

Voluntary Alignment

- Augments claims-based alignment by allowing beneficiaries a decision in their alignment to an ACO.
  - Available to currently- or previously-aligned beneficiaries.
  - During each PY, beneficiaries will have the opportunity to voluntarily align for the subsequent PY.
- ACOs may select the mode(s) of beneficiary confirmation.
- Direct provider-beneficiary communication about voluntary alignment allowed.
- Additional resources for beneficiaries:
  - 1-800-MEDICARE;
  - Regional offices;
  - State Health Insurance Assistance Program counselors.
- Voluntary alignment decisions from other ACO programs/models in 2015 will be retained for ACOs that transition into the Next Generation Model for PY1.

Potential Refinements to Voluntary Alignment

- In later years of the Model, CMS may:
  - Make alignment accessible to a broader group of Medicare beneficiaries, regardless of current or previous alignment;
  - Include affirmation of a general care relationship between beneficiaries and ACOs, instead of between beneficiaries and specific providers; and/or
  - Allow beneficiaries to *opt out* of alignment to a particular ACO in addition to *opting into* ACO alignment.

Benefit Enhancements

- Medicare payment rule waivers designed to improve care coordination and cost saving capabilities:
  - Telehealth expansion
  - Post-discharge home visits
  - 3-Day SNF Rule waiver
- ACO may decide which, if any, to implement.
- For each, ACOs must submit an implementation plan describing how the ACO will utilize, monitor, and report on the benefit enhancement.

Telehealth Expansion

- Elimination of geographic (rural) component of originating site requirements.
- Beneficiaries may receive certain telehealth services from place of residence.
- Telehealth services (CPT and HCPCS codes) unchanged.

Post-Discharge Home Visits

- A licensed clinician under the *general* – instead of direct – supervision of a Next Generation Provider/Supplier or Preferred Provider may bill for “incident to” services at an aligned beneficiary’s home.
- Such services may be furnished not more than one time in the first 10 days following discharge from an inpatient facility (hospital, CAH, SNF, IRF) and not more than one time in the subsequent 20 days.

SNF 3-Day Rule Waiver

- Eliminate the requirement of a 3-day inpatient stay prior to SNF admission.
- Similar to Pioneer Model
  - Available to aligned beneficiaries admitted by Next Generation Providers/Suppliers or Preferred Providers to eligible and CMS-approved SNF Affiliates.
  - Clinical criteria for admission, e.g., beneficiary must be medically stable with confirmed diagnosis of skilled nursing/rehab need.

Beneficiary Coordinated Care Reward

- All Next Generation Beneficiary automatically eligible.
- CMS will notify beneficiaries of their eligibility for a reward and refer them to lists of the ACO's Provider/Suppliers, Preferred Providers, and Affiliates.
- Reward earned if at least a specified percentage of patient encounters are with Next Generation Providers/Suppliers, Preferred Providers, and Affiliates.
- Payment made directly to beneficiaries from CMS.
- Projected values:
  - Reward amount: $50/year ($25 available semi-annually).
  - Reward threshold: 50% of patient encounters with ACO entities.
  - Values may change due to actuarial analysis

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Quality

- The Model will follow Shared Savings Program quality domains, measures, benchmarking methodology, sampling, and scoring.
  - Exception: the measure set will not include the electronic health record (EHR) measure.
- Pay-for-reporting in PY1;
- Pay-for-performance PY2 and later.
  - In PY1, 100% will be used as the quality score when calculating the discount prior to the start of the year.
  - In PY2, the score from the quality data reported for PY1 will be used in calculating the quality component of the discount.
  - In PY3 and later, the score from the quality data reported from 2 years prior will be used in calculating the quality component of the discount but ACOs will have the opportunity to use the score from 1 year prior if it is higher.

Monitoring and Compliance

- Plan designed to protect beneficiaries and address potential program integrity risks.
- New risks require additional safeguards.
- ACOs required to have a compliance officer and develop a compliance plan to be approved by CMS.
- Noncompliance with the terms of the participation agreement will result in corrective actions based on the type of issue, severity, and the ACO's compliance record.

Data Sharing

- CMS will share Medicare data to support care coordination and quality improvement efforts.
- ACOs must enter into a Data Use Agreement with CMS prior to receiving any data.
- ACOs not required to notify beneficiaries of data sharing opt-out option.
  - ACOs will notify beneficiaries of data sharing and respond to inquiring beneficiaries that they may opt out via 1-800-Medicare;
  - Model will honor previous data sharing opt-out decisions by beneficiaries, but these decisions may be reversed through 1-800-Medicare.

Reports

- CMS will provide Next Generation ACOs with data and reports on a regular basis.
- Support ACO analysis of ongoing performance and strategy.
- Reports may include, but are not limited to:
  - Baseline and Benchmark Reports;
  - Quarterly and Annual Utilization;
  - Monthly Expenditures; and
  - Beneficiary Alignment.

Evaluation and Learning

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- Financial Model
  - Benchmark
  - Risk Arrangements
  - Payment Mechanisms
- ACO Entities
  - Next Generation Providers/Suppliers, Preferred Providers, and Affiliates
  - Program Overlap
- Beneficiary Engagement
  - Alignment
  - Voluntary Alignment
  - Benefit Enhancements
- Program Reporting
  - Quality
  - Monitoring and Compliance
  - Data Sharing and Reports
- **Evaluation**
- **Learning System**

Evaluation

- ACOs must cooperate with independent evaluation of the Model.
- Assess the impact of the Model on the goals of better health, better health care, and lower costs.
- Evaluation may include:
  - Participation in surveys;
  - Interviews;
  - Site visits; and
  - Other activities determined necessary by CMS.
- Evaluation seeks to understand, among other areas:
  - Behaviors of providers and beneficiaries;
  - Impacts of increased financial risk;
  - Effects of payment mechanisms and benefit enhancements;
  - Impact on beneficiary engagement and experience.

Learning and Diffusion

- Accelerating ACO progress through a “learning system.”
- CMS will provide opportunities to learn about and share experiences.
- Learning system will use various group learning approaches to help ACOs:
  - Share experiences;
  - Track progress; and
  - Rapidly adopt new methods for improving quality, efficiency, and population health.
- Next Generation ACOs will actively participate in the learning system:
  - Attending periodic conference calls and meetings;
  - Actively sharing tools and ideas through an online collaboration site.

Letter of Intent/Application Information for January 1, 2016 Start

- LOI accessible via Model website: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
  - LOI deadline: 11:59 p.m. EDT, May 1, 2015.
- Application accessible via Model website: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
  - Application deadline: 11:59 p.m. EDT, June 1, 2015.

Questions?

Next Generation ACO Model Webpage:
http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

E-mail: NextGenerationACOModel@cms.hhs.gov

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Next Generation ACO Model

Open Door Forum:

Financial Deep Dive

March 31, 2015

Agenda

- Preliminary Financial Timeline
- Financial Model Deep Dive
  - Benchmark
    - Prospective Benchmark Example
    - Example Discount Calculations
  - Risk Arrangements
    - Example Savings/Losses Calculation
  - Payment Mechanisms
    - Conceptual Diagrams
    - Example Payment Calculations

Preliminary Financial Timeline

Milestone	Date
LOI Due Date	May 1, 2015
Application Due Date	June 1, 2015
Providers/Suppliers List Submitted	June 1, 2015
Financial Methodology Paper	Mid-Summer 2015
Agreements Signed	Fall 2015
Alignment Run and Benchmark Calculated	Mid-Late Fall 2015
Start of 1st Performance Year	January 1, 2016

Next Generation Financial Model

- Key components:
  1. **Benchmark**
     - **Each ACO's benchmark calculated prospectively for the ACO's aligned beneficiaries.**
  2. Risk Arrangement
     - Each ACO selects one of two risk arrangement options.
  3. Payment Mechanism
     - Each ACO selects one of four payment mechanism options.

Prospective Benchmark (2016-2018)

The benchmark will be prospectively set prior to the performance year using the following four steps:

Baseline	Trend	Risk Adjustment	Discount
Determine ACO's baseline using one-year of historical baseline expenditures.	Trend the baseline forward using a regional projected trend.	The full HCC risk score will be used. ACO risk score allowed to grow by 3% between the baseline and the given performance year. ACO risk score decrease also capped at 3%.	Apply discount derived from quality and efficiency adjustments.

Trend (2016-2018)

The baseline will be trended forward using a regional projected trend:

- National projected trend similar to that currently used in Medicare Advantage (MA).
- Regional prices applied to the national trend.
- Under limited circumstances, CMS may adjust the trend in response to price changes with substantial expected impact (negatively or positively) on ACO expenditures.

Risk Adjustment (2016-2018)

- The Next Generation ACO benchmark is cross-sectional:
  - Alignment algorithm applied separately to baseline year and performance year;
  - Populations in these two time periods may be different.
- Prospective CMS Hierarchical Condition Category (HCC) risk scores will be applied to both baseline and performance year populations.
- ACO's full HCC risk score will be allowed to grow with a 3% cap (performance year compared to the baseline). Decrease in HCC risk score will also be capped at 3%.

Discount (2016-2018)

- Once the baseline has been calculated, trended, and risk-adjusted, CMS will apply a discount.
- Summing the following components creates each ACO's discount:
  - Quality:
    - Range: **2.0% to 3.0%**
    - Formula: [2.0 + (1- quality score)]%
  - Regional Efficiency:
    - Range: **-1% to 1%**
    - Compares the ACO's risk-adjusted historical per capita baseline to a risk-adjusted regional FFS per capita baseline.
  - National Efficiency:
    - Range: **-0.5% to 0.5%**
    - Compares the risk-adjusted regional FFS baseline to risk-adjusted national FFS per capita spending.
- Total discount range: **0.5% to 4.5%**

Example ACO A Discount Calculation

Calculating the Discount	Illustrative Amount
1. Quality	
Quality Score	*100%*
Quality Component	2.0%
2. Regional Efficiency	
ACO Risk-Adjusted Baseline	*$8,000*
Regional FFS Risk-Adjusted Baseline	*$8,500*
Regional Efficiency Ratio	*0.94*
Regional Efficiency Discount Component	-0.6%
3. National Efficiency	
Regional FFS Risk-Adjusted Baseline	*$8,500*
National FFS Risk-Adjusted Baseline	*$10,500*
National Efficiency Ratio	*0.81*
National Efficiency Discount Component	-0.5%
Example ACO A Discount	**0.9%**

- In PY1, 100% will be used as the quality score for all Next Generation ACOs:
  - [2.0 + (1-1.0)]%
- Example ACO A's historic baseline expenditures are 6% less expensive than regional FFS—ACO is rewarded for this attainment by having the discount reduced by 0.6%.
- ACO is in a very low cost region (19% below national FFS)—ACO is rewarded with 0.5% discount reduction (the maximum regional-to-national FFS discount reduction).

Example ACO B Discount Calculation

Calculating the Discount	Illustrative Amount
1. Quality	
Quality Score	*100%*
Quality Component	2.0%
2. Regional Efficiency	
ACO Risk-Adjusted Baseline	*$12,000*
Regional FFS Risk-Adjusted Baseline	*$13,000*
Regional Efficiency Ratio	*0.92*
Regional Efficiency Discount Component	-0.8%
3. National Efficiency	
Regional FFS Risk-Adjusted Baseline	*$13,000*
National FFS Risk-Adjusted Baseline	*$11,500*
National Efficiency Ratio	*1.13*
National Efficiency Discount Component	0.4%
Example ACO B Discount	**1.6%**

- In PY1, 100% will be used as the quality score for all Next Generation ACOs:
  - [2.0 + (1-1.0)]%
- Example ACO B's historic baseline expenditures are 8% less expensive than regional FFS—ACO is rewarded for this attainment by having the discount reduced by 0.8%.
- ACO is in a region whose spending is 13% higher than national FFS—ACO's discount is increased by 0.4% to reflect this regional-to-national FFS differential.

Prospective Benchmark Example

Benchmark Step	Illustrative Amount	Description
Baseline Spending/ Baseline Risk Score	$100/1.00	Run alignment in baseline year to determine ACO's historic expenditures and baseline risk.
Trend	2.0%	Add trend to the baseline: $100 + (.02 x $100) = $102
Risk Adjustment	1.02	Risk adjust the trended baseline using risk score for PY aligned beneficiaries: $102 x 1.02 = $104.04
Discount	1.0%	Subtract discount: $104.04 – (.01 x $104.04)
Illustrative Benchmark	$103.36	--

Next Generation Financial Model

- Key components:
  1. Benchmark
     - Each ACO's benchmark calculated prospectively for the ACO's aligned beneficiaries.
  2. **Risk Arrangement**
     - **Each ACO selects one of two risk arrangement options.**
  3. Payment Mechanism
     - Each ACO selects one of four payment mechanism options.

Risk Arrangements

Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Parts A and B Shared Risk • 80% sharing rate (PY1-3, 2016-2018) • 85% sharing rate (PY4-5, 2019-2020) • 15% savings/losses cap • Discount	100% Risk for Parts A and B • 15% savings/losses cap • Discount

- Benchmarks calculated the same way for both arrangements.
- For both arrangements, individual expenditures capped at the 99th percentile of expenditures to moderate outlier effects.

Example Savings/Losses Calculation

Shared Savings/Loss Reconciliation	Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Illustrative Benchmark	$100,000,000	$100,000,000
Sharing Rate	80%	100%
Savings/Losses Cap	15%	15%
Maximum Savings/Losses	+/- $12,000,000 [80% x (15% x $100,000,000)]	+/- $15,000,000 [100% x (15% x $100,000,000)]
Actual PY Expenditures	$97,000,000	$97,000,000
Shared Savings Payment	$2,400,000	$3,000,000
Actual PY Expenditures	$103,000,000	$103,000,000
Shared Losses Owed	$2,400,000	$3,000,000

- Savings or losses determined by comparing total Parts A and B spending for aligned beneficiaries to the benchmark.
- Risk arrangement determines ACO's share of savings or losses.

Next Generation Financial Model

- Key components:
  1. Benchmark
     - Each ACO's benchmark calculated prospectively for the ACO's aligned beneficiaries.
  2. Risk Arrangement
     - Each ACO selects one of two risk arrangement options.
  3. **Payment Mechanism**
     - **Each ACO selects one of four payment mechanism options.**

Payment Mechanisms

Payment Mechanism 1: Normal FFS	Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payment	Payment Mechanism 3: Population-Based Payments (PBP)	Payment Mechanism 4: Capitation (PY2 or later)
Medicare payment through usual FFS process.	Medicare payment through usual FFS process plus additional PBPM payment to ACO.	Medicare payment redistributed through reduced FFS and PBPM payment to ACO.	Medicare payment through capitation; ACO responsible for paying Provider/Supplier and Capitation Affiliate claims

- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures.
- Payments to ACOs will be reconciled and may result in other monies owed.

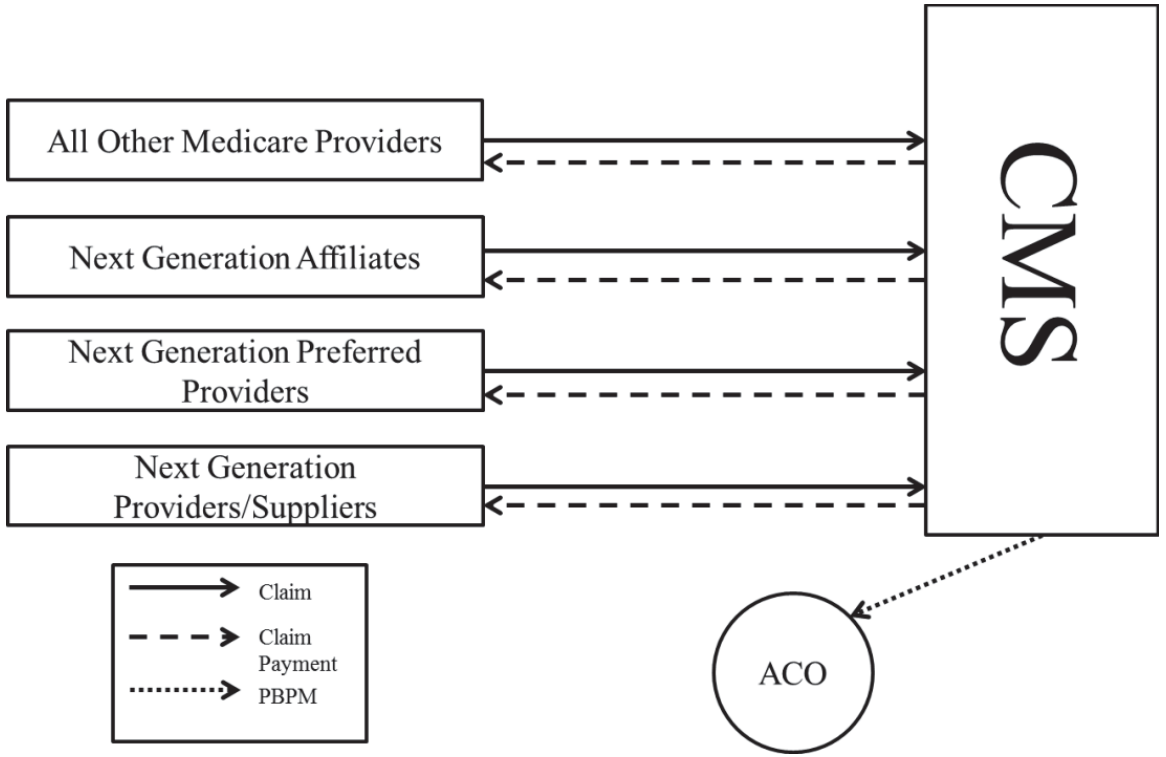
Types of Next Generation ACO Entities

- Next Generation Providers/Suppliers
  - Primary component of a Next Generation ACO, cannot be any of the other provider types.
  - Used for program activities, including beneficiary alignment and quality reporting through the ACO.
  - ACO's selection of benefit enhancements and payment mechanism automatically extend to these providers.
- Next Generation Preferred Providers
  - May offer an ACO's benefit enhancements to aligned beneficiaries.
- Capitation Affiliates
  - ACO partner for purposes of participating in capitation.
  - Preferred Providers may also be Affiliates.

Infrastructure Payments

- All claims paid through normal FFS reimbursement.
- The ACO chooses an additional per-beneficiary per-month (PBPM) payment unrelated to claims.
- Maximum payment rate: $6 PBPM
- All infrastructure payments will be recouped in full from the ACO during reconciliation regardless of savings or losses.
- Sufficiently large financial guarantee required to assure repayments of to CMS.

Infrastructure Payments Conceptual Diagram



All providers/suppliers submit claims to CMS as normal, and CMS pays all claims as normal. Unrelated to claims, CMS makes a monthly per-beneficiary per-month (PBPM) payment to the ACO.

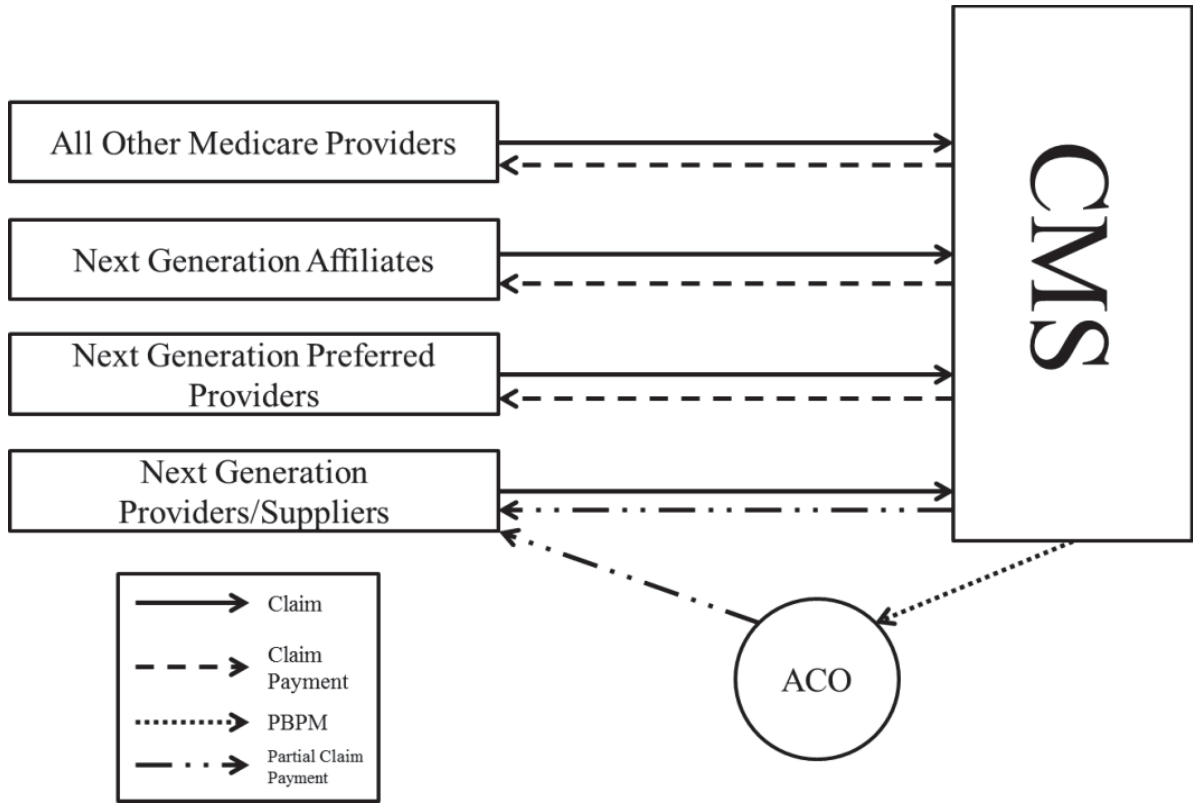
Population Based Payments (PBP)

- ACO determines a percentage reduction to the base FFS payments of its Providers/Suppliers.
  - ACO may opt to apply a different percentage reduction to different subsets of its Providers/Suppliers.
  - Providers/Suppliers participating in PBP must agree in writing to the percentage reduction.
- CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments.

PBP Example Calculation

Example ACO	Amount	Description
# Aligned Beneficiaries	25,000	--
Benchmark (Projected Spending)	$300,000,000 ($12,000 PBPY = $1,000 PBPM)	Benchmark calculated using model benchmark methodology.
Projected Spending by PBP participating providers/suppliers	75%	Using historic claims, CMS projects spending by providers participating in PBP.
FFS % Reduction	10%	Providers agree to reduction off base FFS rates.
PBPM to ACO	$75	10% of 75% of $1,000 PBPM
Monthly Payment to ACO	$1,875,000	$75 PBPM x 25,000 aligned beneficiaries
Annual Amount Paid to ACO	$22,500,000	$1,875,000 monthly payment x 12 months

Population-Based Payments Conceptual Diagram



All providers/suppliers submit claims to CMS as normal. CMS pays Next Generation Providers/Suppliers participating in PBP reduced FFS rates and pays the ACO a PBPM payment with which the ACO pays Next Generation Providers/Suppliers according to written agreements.

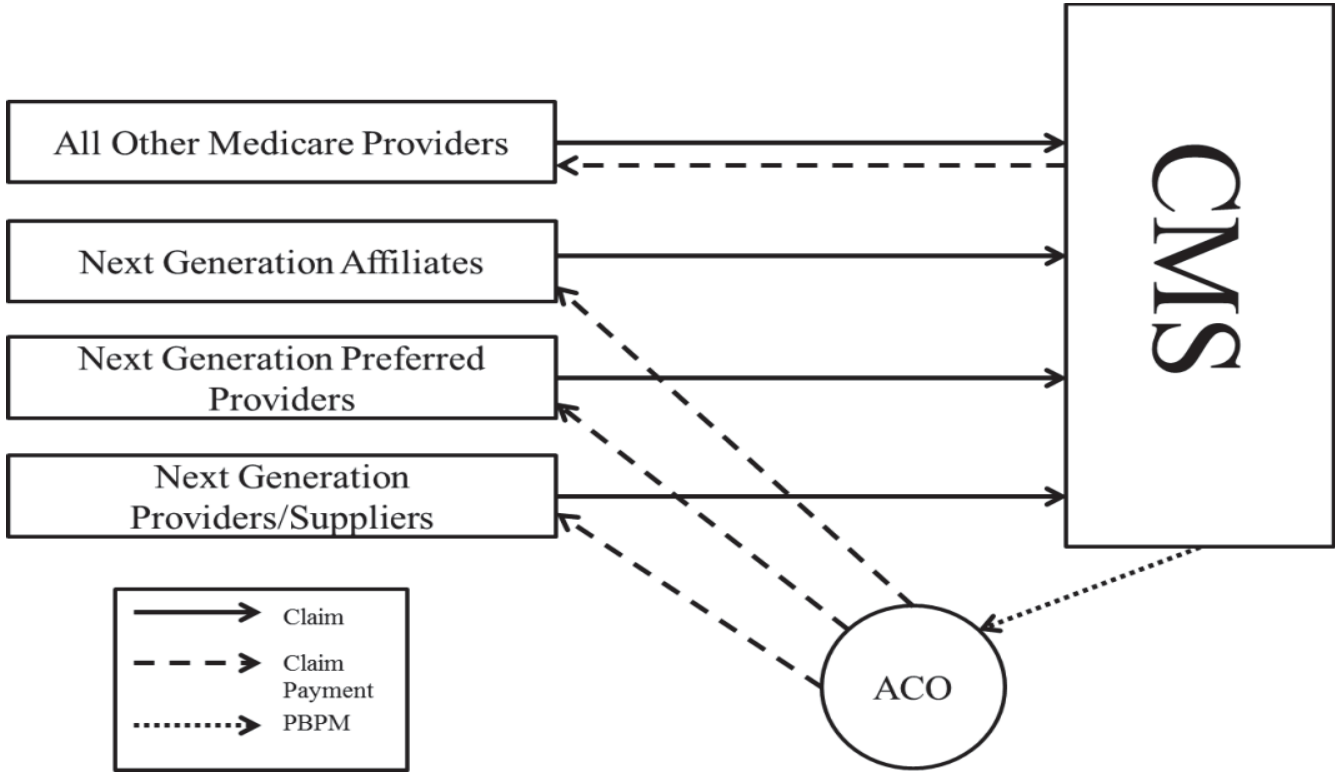
Capitation (available in 2017)

- CMS will estimate total annual expenditures for Next Generation Beneficiaries and pay that projected amount to the ACO in a PBPM payment.
- Some money withheld to cover anticipated care by non-ACO providers and suppliers.
- ACO responsible for paying claims for its Providers/Suppliers and Capitation Affiliates.
- Claims process:
  - All providers and suppliers submit claims to CMS as normal
  - CMS sends ACOs claims information for those services
  - ACO responsible for making payments.
- CMS will continue to pay normal FFS claims for care furnished to Next Generation Beneficiaries by providers and suppliers not covered by a Next Generation capitation agreement.

Capitation Example Calculation (2017)

Example ACO	Amount	Description
# Aligned Beneficiaries	25,000	--
Benchmark (Projected Spending)	$300,000,000 ($12,000 PBPY = $1,000 PBPM)	Benchmark calculated using model benchmark methodology.
Projected Spending by ACO Providers and Capitation Affiliates	75%	Using historic claims, CMS projects spending by providers participating in capitation.
Capitation PBPM	$750	75% of $1,000 PBPM
Monthly Payment to ACO	$18,750,000	$750 capitation PBPM x 25,000 aligned beneficiaries
Annual Amount Paid to ACO	$225,000,000	$18,750,000 monthly payment x 12 months

Capitation Conceptual Diagram (2017)



All providers/suppliers submit claims to CMS as normal. CMS will pay the ACO a monthly PBPM capitation payment with which the ACO will be responsible for paying capitated entities. ACOs will receive claims and payment information from CMS to inform payment to Next Generation Providers/Suppliers, Preferred Providers, and Affiliates participating in capitation. CMS will continue to pay FFS claims for all unaffiliated Medicare providers.

Payment Mechanism Reconciliation

- Separate reconciliation for infrastructure payments, PBP, and capitation.
- Infrastructure payments fully recouped from savings or in addition to losses.
- PBP and capitation reconciled to account for actual spending versus projection, may result in other monies owed to CMS or ACO.

PBP Reconciliation Example

Projections used to calculate PBP:

Example ACO	Amount
# Aligned Beneficiaries	25,000
Benchmark (Projected Spending)	$300,000,000 ($12,000 PBPY = $1,000 PBPM)
Projected Spending by PBP participating providers/suppliers	75%
Annual Amount Paid to ACO	$22,500,000

- During reconciliation, CMS determines 70% of care was delivered by PBP participating providers.
- ACO should have been paid $21,000,000 = ACO owes CMS $1,500,000 in other monies owed.
- Similar reconciliation will occur for capitation to account for projected versus actual spending.

Questions?

Next Generation ACO Model Webpage:
http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

E-mail: NextGenerationACOModel@cms.hhs.gov

Restore Health
Reasonableness Test for Projected Volume
Based on UMMS Demand in Baltimore City: UMMC and UMMC Midtown

Population A: Hard-to-place patients / Bed shortage

	ESTIMATED CURRENT PLACEMENTS (2014-2015)			PROJECTED VOLUME FOR RESTORE HEALTH (2018)				
Patient Population	Total UMMC Placements (est)	Total Midtown Placements (doc)	Projected Capture Rate	Total Discharges	ALOS	Total Days	ADC Demand	Demand for Beds @ 90% Occupancy
Dialysis and Vent	120	44	75%	123	80	9,840	27	30
Dialysis	240	85	10%	33	80	2,600	7	8
Bariatrics	60	84	10%	14	80	1,152	3	4
TOTAL (A), Delayed Transfers to Nursing Homes	**420**	**213**	**27%**	**170**	**80**	**13,592**	**37**	**41**

Population B: Complex medical; special resources/capabilities required

	ESTIMATED CURRENT PLACEMENTS (2014-2015)			PROJECTED VOLUME FOR RESTORE HEALTH (2018)				
Patient Population	Total UMMC Placements (est)	Total Midtown Placements (doc)	Projected Capture Rate	Total Discharges	ALOS	Total Days	ADC Demand	Demand for Beds @ 90% Occupancy
Complex Medical	200	22	90%	200	18	3,596	10	11
TOTAL (B), New Transfers to Nursing Homes	**200**	**22**	**90%**	**200**	**18**	**3,596**	**10**	**11**

Population C: % City Residents Using Out of Area Nursing Homes

	ESTIMATED CURRENT PLACEMENTS (2014-2015)		PROJECTED VOLUME FOR RESTORE HEALTH (2018)				
Patient Population	Total Recorded by MDS [3]	Projected Capture Rate	Total Discharges	ALOS	Total Days	ADC Demand	Demand for Beds @ 90% Occupancy
5% of West Baltimore residents using out of area	**1,300**	**5%**	65	**120**	**7,800**	**21**	**24**
TOTAL (C), Redirection from out of area nursing homes	**1,300**	**5%**	**65**	**120**	**7,800**	**21**	**24**

Population D: PQIs: Avoidable Hospital Admissions

	ESTIMATED CURRENT PLACEMENTS (2014-2015)			PROJECTED VOLUME FOR RESTORE HEALTH (2018)				
Patient Population	Total UMMC Placements	Total Midtown Placements	Projected Capture Rate	Total Discharges	ALOS	Total Days	ADC Demand	Demand for Beds @ 90% Occupancy
Subtotal, PQIs, Direct Admits, Non-Medicare	**629**	**240**	**25%**	**217**	**4**	**869**	**2**	**3**
Subtotal, PQIs, Direct Admits, Medicare	**600**	**274**	**50%**	**437**	**4**	**1,748**	**5**	**5**
TOTAL (D), New Direct Admits to Nursing Homes	**1,229**	**514**	**50%**	**654**	**4**	**2,617**	**7**	**8**
Grand Total, Restore Health, with 3 day waiver				**1,089**	**25**	**27,605**	**76**	**84**
Grand Total, Restore Health, absent 3 day waiver				**652**	**40**	**25,857**	**71**	**79**

Sources:

[1] UMMC Placements and Midtown Placements: Estimates from caseworkers at each hospital

[2] PQI discharges: HSCRC Discharge Abstract Database, FY2014

[3] Out of area placements based on Long Term Care Minimum Dataset provided by the MHCC

Prevention Quality Indicators Overview

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

The PQIs can be used as a "screening tool" to help flag potential health care quality problem areas that need further investigation; provide a quick check on primary care access or outpatient services in a community by using patient data found in a typical hospital discharge abstract; and, help public health agencies, State data organizations, health care systems, and others interested in improving health care quality in their communities.

With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community. Because the PQIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to provide a window into the community — to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.

http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

PQI Discharges at Baltimore City Hospitals
Fiscal Year 2014

Medicare Patients Only

	UMMC Midtown Campus			University of Maryland Medical Center			All Other City Hospitals			Total		
MS-DRG	Cases	Avg. Length of Stay	Avg. Charge per Case	Cases	Avg. Length of Stay	Avg. Charge per Case	Cases	Avg. Length of Stay	Avg. Charge per Case	Cases	Avg. Length of Stay	Avg. Charge per Case
PQI 08 Heart Failure	75	5	$16,495	187	6	$16,210	2,892	5	$13,152	3,154	5	$13,413
PQI 05 COPD or Asthma in Older Adults	71	4	13,838	83	6	36,444	1,696	4	11,546	1,850	4	12,751
PQI 11 Bacterial Pneumonia	41	4	12,272	44	5	14,338	1,131	5	12,356	1,216	5	12,425
PQI 12 Urinary Tract Infection	12	4	11,931	67	4	10,522	1,028	4	9,027	1,107	4	9,149
PQI 03 Diabetes Long-Term	29	5	20,086	101	7	55,632	782	5	20,157	912	6	24,083
PQI 10 Dehydration	9	4	13,115	43	3	10,197	624	4	9,398	676	4	9,498
PQI 07 Hypertension	10	4	12,801	34	3	8,421	320	3	8,828	364	3	8,899
PQI 01 Short-term Diabetes	13	4	13,754	14	6	18,728	230	4	11,365	257	4	11,887
PQI 16 Lower Extremity Amputation among Patients with Diabetes	10	14	71,755	16	18	80,985	157	13	49,630	183	13	53,581
PQI 13 Angina without Procedure	-	-	-	8	2	9,936	72	2	8,713	80	2	8,836
PQI 14 Uncontrolled Diabetes	3	8	8,315	1	5	13,039	56	4	8,306	60	4	8,385
PQI 15 Asthma in Younger Adults	1	4	15,790	2	1	5,405	21	3	8,297	24	3	8,368
Total	**274**	**5**	**$16,903**	**600**	**6**	**$25,662**	**9,009**	**5**	**$12,986**	**9,883**	**5**	**$13,865**

Non-Medicare Patients

	UMMC Midtown Campus			University of Maryland Medical Center			All Other City Hospitals			Total		
MS-DRG	Cases	Avg. Length of Stay	Avg. Charge per Case	Cases	Avg. Length of Stay	Avg. Charge per Case	Cases	Avg. Length of Stay	Avg. Charge per Case	Cases	Avg. Length of Stay	Avg. Charge per Case
PQI 05 COPD or Asthma in Older Adults	47	2	10,534	93	3	13,820	1,513	3	9,702	1,653	3	9,958
PQI 08 Heart Failure	33	4	14,790	159	5	15,257	1,328	5	12,576	1,520	5	12,905
PQI 11 Bacterial Pneumonia	22	3	11,991	87	4	12,684	930	4	11,068	1,039	4	11,223
PQI 03 Diabetes Long-Term	40	4	15,427	71	5	50,577	819	5	16,933	930	5	19,437
PQI 01 Short-term Diabetes	37	3	10,143	48	3	8,102	638	3	9,221	723	3	9,194
PQI 12 Urinary Tract Infection	6	2	8,015	51	4	12,869	537	3	8,154	594	3	8,557
PQI 10 Dehydration	12	3	10,032	37	5	16,815	418	3	9,266	467	3	9,883
PQI 07 Hypertension	21	3	12,587	41	2	9,561	400	2	7,607	462	2	8,007
PQI 15 Asthma in Younger Adults	12	2	7,450	16	2	7,331	292	2	7,452	320	2	7,446
PQI 16 Lower Extremity Amputation among Patients with Diabetes	5	9	30,011	11	13	50,641	75	12	42,679	91	12	42,946
PQI 14 Uncontrolled Diabetes	4	3	7,291	2	4	10,555	77	2	5,976	83	2	6,150
PQI 13 Angina without Procedure	1	3	11,015	13	2	9,000	64	2	9,155	78	2	9,153
Total	**240**	**3**	**12,299**	**629**	**4**	**17,929**	**7,091**	**4**	**11,161**	**7,960**	**4**	**11,730**

Notes:
[1] PQI 02 Perforated Appendix excluded from the analysis
[2] All other city hospitals include St. Agnes, Sinai, Mercy, Johns Hopkins, Johns Hopkins Bayview, Bon Secours, MedStar Harbor, MedStar Good Samaritan, MedStar Union Memorial

Summary of Cases with Prevention Quality Indicators
Baltimore City Hospitals
Fiscal Year 2014

Medicare Patients Only

MS-DRG	UMMC Midtown Campus	University of Maryland Medical Center	Mercy Medical Center	Johns Hopkins Hospital	St. Agnes Hospital	Sinai Hospital	Bon Secours Hospital	MedStar Union Memorial Hospital	Johns Hopkins Bayview Medical Center	MedStar Harbor Hospital Center	MedStar Good Samaritan Hospital	Total
PQI 08 Heart Failure	75	187	191	444	407	468	59	308	447	176	392	3,154
PQI 05 COPD or Asthma in Older Adults	71	83	128	153	308	188	100	165	297	171	186	1,850
PQI 11 Bacterial Pneumonia	41	44	75	117	293	144	27	128	163	73	111	1,216
PQI 12 Urinary Tract Infection	12	67	82	98	236	179	25	65	143	65	135	1,107
PQI 03 Diabetes Long-Term	29	101	55	165	89	127	19	63	127	36	101	912
PQI 10 Dehydration	9	43	41	88	102	138	15	30	93	24	93	676
PQI 07 Hypertension	10	34	11	49	59	54	10	21	42	9	65	364
PQI 01 Short-term Diabetes	13	14	9	35	31	47	9	21	32	15	31	257
PQI 16 Lower Extremity Amputation among Patients with Diabetes	10	16	15	24	18	18	5	20	26	6	25	183
PQI 13 Angina without Procedure	-	8	8	12	8	5	2	3	20	5	9	80
PQI 14 Uncontrolled Diabetes	3	1	4	5	11	12	-	6	8	2	8	60
PQI 15 Asthma in Younger Adults	1	2	-	4	1	3	1	4	2	3	3	24
Total	**274**	**600**	**619**	**1,194**	**1,563**	**1,383**	**272**	**834**	**1,400**	**585**	**1,159**	**9,883**

Non-Medicare Patients

MS-DRG	UMMC Midtown Campus	University of Maryland Medical Center	Mercy Medical Center	Johns Hopkins Hospital	St. Agnes Hospital	Sinai Hospital	Bon Secours Hospital	MedStar Union Memorial Hospital	Johns Hopkins Bayview Medical Center	MedStar Harbor Hospital Center	MedStar Good Samaritan Hospital	Total
PQI 05 COPD or Asthma in Older Adults	47	93	112	244	224	178	114	114	239	153	135	1,653
PQI 08 Heart Failure	33	159	79	338	138	150	64	110	220	69	160	1,520
PQI 11 Bacterial Pneumonia	22	87	73	172	169	90	50	108	132	61	75	1,039
PQI 03 Diabetes Long-Term	40	71	58	191	121	128	39	65	100	32	85	930
PQI 01 Short-term Diabetes	37	48	35	138	110	103	22	44	86	38	62	723
PQI 12 Urinary Tract Infection	6	51	75	105	84	62	28	29	71	27	56	594
PQI 10 Dehydration	12	37	32	141	56	45	14	17	53	14	46	467
PQI 07 Hypertension	21	41	14	82	64	58	11	45	37	22	67	462
PQI 15 Asthma in Younger Adults	12	16	23	68	44	49	17	20	32	17	22	320
PQI 16 Lower Extremity Amputation among Patients with Diabetes	5	11	8	15	11	5	2	9	10	1	14	91
PQI 14 Uncontrolled Diabetes	4	2	6	9	10	20	2	10	9	5	6	83
PQI 13 Angina without Procedure	1	13	8	14	4	4	10	2	14	4	4	78
Total	**240**	**629**	**523**	**1,517**	**1,035**	**892**	**373**	**573**	**1,003**	**443**	**732**	**7,960**

Notes:
[1] PQI 02 Perforated Appendix excluded from the analysis
[2] Assumption of an average LOS of 4 days per patient at Mid-Atlantic
[3] All other city hospitals include St. Agnes, Sinai, Mercy, Johns Hopkins, Johns Hopkins Bayview, Bon Secours, MedStar Harbor, MedStar Good Samaritan, MedStar Union Memorial