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April 7, 2017

Via Hand Delivery
Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Broadmead, Inc.
CON Application for Capital Expenditure

Dear Ms. Potter:

Please be advised that I represent Broadmead, Inc. and am filing, on its behalf, its CON application for Capital Expenditure.

Enclosed please find six (6) binders containing the Table of Contents, application, CON Tables, Project Drawings, Materials for Prospective Residents, Discharge Planning Policy, QA Policy, most recent audited financials, financing letter, letters of support and affirmations.

A pdf of the documents and a Word document of the application will be sent via e-mail to you and Mr. McDonald.

Thank you for your assistance with this matter.

Very truly yours,

Rose M. Matricciani

RMM:mrm

Enclosures:
6 binders each containing the following documents:
Table of Contents

1. Application
2. CON Table Package
3. Project Drawings
4. Materials for Prospective Residents
5. Discharge Planning Policy
6. Quality Assurance Policy
7. Audited Financial Statement
8. Financing Letter
9. Letters of Support
10. Affirmations

cc: Robin Somers, Chief Operating Officer
Broadmead, Inc.

John Palkovitz, Chief Financial Officer
Broadmead, Inc.

John J. Peacock, CPA, ALA, Principal
ARCH Consultants Ltd.

Andrew L. Solberg, Consultant
A.L.S. Healthcare Consultant Services

2240981

BROADMEAD, INC.

APPLICATION FOR CON
FOR
CAPITAL EXPENDITURE

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Tab 10

Affirmation Statements

Robin Somers, COO, Broadmead, Inc.
John Palkovitz, CFO, Broadmead, Inc.
John J. Peacock, CPA, ALA, Principal, ARCH Consultants Ltd.
Ann Patterson, LNHA, ALM, CDP, Health Care Administrator, Broadmead, Inc.
Dana Anders, CPA, Manager, Health Care, CliftonLarsonAllen LLP
Andrew L. Solberg, Healthcare Consultant, A.L.S. Healthcare Consultant Services

TABS

1. Application
2. CON Table Package
3. Project Drawings
4. Materials for Prospective Residents
5. Discharge Planning Policy
6. Quality Assurance Policy
7. Audited Financial Statement
8. Financing Letter
9. Letters of Support
10. Affirmations

2240574v2

TAB 1

APPLICATION

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

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

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

Required Format:

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

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

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

SUBMISSION FORMATS:

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

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

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

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

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

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

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

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

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

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Broadmead, Inc.**

Address:

13801 York Road	**Cockeysville**	**21030**	**Baltimore**
Street	City	Zip	County

2. Name of Owner

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

Broadmead, Inc. is a not-for-profit, Maryland non-stock Corporation. The sole member of the corporation is Friends Care, Inc., also a not-for-profit, Maryland non-stock Corporation. Friends Care, Inc. is located at 13801 York Road, Cockeysville, Maryland 21030. Broadmead, Inc. is a qualified tax-exempt organization as described in Section 501(c) (3) of the Internal Revenue Code. Therefore, no person has an ownership interest in Broadmead, Inc.

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

Legal Name of Project Applicant (Licensee or Proposed Licensee):

Address:

Street	City	Zip	State	County
Telephone:				

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

Broadmead, Inc.

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation MD 1/22/76
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

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

A. Lead or primary contact:

Name and Title: Robin R. Somers, LCSW-C, NHA

Company Name Broadmead, Inc.

Mailing Address:

13801 York Road	Cockeysville	21030	MD
Street	City	Zip	State

Telephone: 443-578-8004

E-mail Address (required): rsomers@broadmead.org

Fax: 443-578-8198

If company name is different than applicant briefly describe the relationship

B. Additional or alternate contact:

Name and Title: Rose M. Matricciani, Partner

Company Name Whiteford, Taylor & Preston, L.L.P.

Mailing Address:

7 St. Paul Street	Baltimore	21202	MD
Street	City	Zip	State

Telephone: 410-347-9476
E-mail Address (required): rmatricciani@wtplaw.com

Fax: 410-234-2355

If company name is different than applicant briefly describe the relationship Attorney

C. Additional or alternate contact:

Name and Title: Andrew Solberg - Consultant

Company Name: A.L.S. Healthcare Consultant Services

Mailing Address:

5612 Thicket Lane	Columbia	21044	MD
Street	**City**	**Zip**	**State**

Telephone: 410-730-2664

E-mail Address (required): asolberg@earthlink.net

Fax:

If company name is different than applicant briefly describe the relationship Consultant

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

Legal Name of the Owner of the Real Property
Broadmead, Inc.

Address:

13801 York Road	Cockeysville	21030	MD	Baltimore
Street	City	Zip	State	County

Telephone: **410-527-1900**

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

Broadmead, Inc. is a not-for-profit, Maryland non-stock Corporation. The sole member of the corporation is Friends Care, Inc., also a not-for-profit, Maryland non-stock Corporation. Friends Care, Inc. is located at 13801 York Road, Cockeysville, Maryland 21030. Broadmead, Inc. is a qualified tax-exempt organization as described in Section 501(c) (3) of the Internal Revenue Code. Therefore, no person has an ownership interest in Broadmead, Inc.

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

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

Broadmead, Inc.

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

Address:

Street	City	Zip	State	County

Telephone:

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

Name of Management Company

Address:

Street City Zip State County

Telephone:

10. TYPE OF PROJECT

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

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

(1) A new health care facility built, developed, or established ☐
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: ☒
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf

11. PROJECT DESCRIPTION

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

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

A renovation and modification project, expanding space, no change in beds.

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

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

Please see the following page.

Project Description

Broadmead, Inc. is a not-for-profit, Maryland non-stock corporation. It is a qualified tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code. Broadmead is a continuing care retirement community located in Cockeysville, Baltimore County, Maryland and consists of 265 independent living units, 30 assisted living beds and 70 skilled nursing beds. Broadmead opened in 1979 as a community with Quaker roots. The Community also includes a central building containing administrative offices, recreational, meeting and dining amenities.

In 2014, under the guidance of a new CEO and Executive Leadership Team, the Board of Trustees embarked upon developing a comprehensive and progressive strategic plan for the 36 year old Broadmead Community. As a result of multiple market studies, a resident satisfaction survey, an employee satisfaction survey and engaging stakeholders in focus groups, four key organizational strategic goals were identified: (1) provide exceptional senior living services and superior healthcare to [our] residents; (2) establish and maintain a person-centered culture that respects the independence, choice and dignity of each individual; (3) create Centers of Excellence in programs and environments in senior living and healthcare; and (4) expand programs, on and off the Broadmead Campus, to a population of older adults more reflective of the economic levels and socio-cultural demographics of the mid-Atlantic region. In response to these strategic goals, a Master Plan was created for repositioning and renovating the campus.

The Master Plan includes the following: (a) renovation of comprehensive care space to include a 17 bed short term rehabilitation household, a 13 bed skilled nursing dementia care household, a 27 bed skilled nursing long-term care household and a 13 bed skilled nursing household adjacent to the existing assisted living household; (b) addition of a new Memory Support assisted living household with 14 new licensed AL beds; (c) expanded parking for residents, employees and visitors; (d) renovation of common areas creating a new bistro, resident library, resident meeting room, Resident Association offices and renovating the auditorium and convenience store; (e) expansion and renovation of the Holly Terrace Dining Room to include an additional private dining room, additional seating, enhanced meal service and storage for mobility devices; (f) creation of dedicated space to support a Center of Excellence for health and wellness; (g) replacement of the existing pool with a new and enlarged indoor pool with renovated and enlarged changing rooms and showers; (h) relocation of the Finance Department and Board Room; (i) relocation of the Resident Art Studio, Ceramics Studio and Salon; (j) relocation and redesign of the campus entrance; (k) addition of two new independent living apartment buildings consisting of 26 homes in each building with lower level covered parking; (l) minor renovation of interior finishes of the first floor of historic Holly House; and (m) addition of a one-story maintenance building.

The Project

The skilled nursing component of this project maintains Broadmead's current inventory of 70 licensed skilled nursing beds with no new beds being added or requested. Since it opened, all of Broadmead's 70 skilled beds have had the ability to admit residents from the public.

One aspect of the skilled nursing project involves converting a 40 bed skilled nursing unit into two households of clusters of 10 and 13 rooms respectively. Except for four resident rooms that are designed to be shared with a private bathroom, resident rooms will be private and have a private bathroom. In addition, each household will promote the social model of care and contain dining, an activity kitchen and social spaces organized around an exterior courtyard. The courtyard will provide access to outdoors and natural light.

An 11 room (13 bed) skilled nursing household will be developed to meet the needs of residents with a diagnosis of dementia. The residents will be provided with dining, an activity kitchen, social spaces and direct access to a secure outdoor courtyard. Two of the rooms will be designed to accommodate couples while the other rooms will be private.

An 11 room (13 bed), traditional skilled nursing household will be provided with dining, an activity kitchen and social spaces. Two of the rooms are designed to be shared to accommodate couples. This neighborhood is in a proposed addition expanding the existing health center building and will be located on the third floor.

A 17 bed rehabilitation household will be developed as part of the skilled nursing project. This household will be designed to center on the needs of residents seeking short-term rehabilitation services, and will include dining and social spaces appropriately sized for this short-term population. This rehabilitation household will have direct elevator access to the recently renovated physical therapy gym. All resident rooms will be private with private bathrooms.

The household model for skilled nursing care was chosen because it provides a person-centered approach that helps the resident transition from a traditional family home environment to an environment that is set up in a similar manner, to create a genuine home atmosphere while providing seniors with opportunities to direct their own lives. Similar to the home environment, the residents have their own kitchen, dining and living areas with access to the outside.

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

Tab 2 includes the entire CON Table Package.

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

Broadmead offers home based services through Friends Circle, Inc., a licensed residential services agency, regulated by the Maryland Department of Health and Mental Hygiene, Office of Healthcare Quality that provides support for functionally disabled persons in their communities, meeting their health and social needs to improve quality of life through optimal independence in the least restrictive setting. These services will not be impacted by the project.

14. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 94 acres

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

Description	Projected Date of Completion	Actual Date of Completion
A. Zoning Process		
1. IL Zoning Hearing	02/2016	02/2016
2. IL Zoning Approved	03/2016	03/2016
3. Appeals	N/A	
3. Development Plan Approval	07/15/17	
B. Permits and Other approvals		
1. Building Permits issued		
a. Site and Grading	08/2018	
b. Foundation Permit	08/2018	
c. Building Permit	10/2018	
d. Other		
2. Fire and Life Safety Code Approvals	10/2018	
3. Other:		
4. Other:		
C. Architectural Plans Status:		
D. Department of Aging	06/2017	

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

(1) Owned by: Broadmead, Inc.

(2) Options to purchase held by: _____

Please provide a copy of the purchase option as an attachment.

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

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

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

15. PROJECT SCHEDULE

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

	Proposed Project Timeline	
Obligation of 51% of capital expenditure from approval date	20	months
Initiation of Construction within 4 months of the effective date of a binding construction contract	1	months
Time to Completion of Construction from date of capital obligation	24	months

16. PROJECT DRAWINGS

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

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

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

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

C. Specify dimensions and square footage of patient rooms.

Tab 3 includes Project Drawings

17. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction and

Renovation Square Footage worksheet in the CON Table Package (Table B)

Tab 2 includes the entire CON Table Package.

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

All utilities are available on site.

PART II - PROJECT BUDGET

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

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

Tab 2 includes the entire CON Table Package.

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

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

   - John E. Howl, Chief Executive Officer, 13801 York Road, Cockeysville, MD 21030 (June 2013 – Present)

   - Ann A. Patterson, LNHA, ALM, CDP, Health Care Administrator, 377 Klee Mill Road, Sykesville, MD 21784 (March 2016 to Present)

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

   - John E. Howl has not been involved in the ownership, development or day-to-day individual facility management of another health care facility for 20 years. His experience during this period has been in various leadership positions within multi-site provider organizations.

   - Ann A. Patterson has not been involved in the ownership or development of another health care facility. She has been involved in management of one additional health care facility:
     Fairhaven, 7600 Third Avenue, Sykesville, Maryland 21784 (December 2014 to February 2016)

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

   No

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

   No

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

   No

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

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

3/31/17
Date

Signature of Owner or Board-designated Official

President & CEO
Position/Title

JOHN E. Howl
Printed Name

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

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

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

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

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

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

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

10.24.08.05 Nursing Home Standards.

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

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

The most recent MHCC Comprehensive Care Bed Need Projections for Baltimore City were for target year 2016 and were published by the MHCC in the *Maryland Register* on 4/16/2016.

(2) Medical Assistance Participation.

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

---

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

participate, in the Medical Assistance Program, and only if the applicant submits documentation or agrees to submit documentation of a written Memorandum of Understanding with Medicaid to maintain the proportion of Medicaid patient days required by .05A 2(b) of this Chapter.

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

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

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

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

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

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

Broadmead does not yet participate in the Medical Assistance Program. Broadmead will sign the MOU prior to seeking first use approval. The most recently published applicable Medicaid percentage requirement (*Maryland Register*, 2/5/2016, p. 303) is 42.5 percent. Broadmead agrees to meet all of the requirements of this standard in regard to the patient days generated by admissions from the public (i.e., not Broadmead CCRC members). Broadmead will not count any Medicaid days generated by Broadmead CCRC members in the percentage.

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

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

(b) Initiating discharge planning on admission; and

(c) Permitting access to the facility for all "Olmstead" efforts approved by the

Department of Health and Mental Hygiene and the Department of Disabilities to provide education and outreach for residents and their families regarding home and community-based alternatives.

Broadmead offers home based services through Friends Circle, Inc., a licensed residential services agency, regulated by the Maryland Department of Health and Mental Hygiene, Office of Healthcare Quality that provides support for functionally disabled persons in their communities, meeting their health and social needs to improve quality of life through optimal independence in the least restrictive setting.

Broadmead will provide information to all prospective residents from the public about the existence of alternative community-based services, including but not limited to Medicaid home and community-based waiver programs, home care, medical day care, assisted living, and other initiatives to promote care in the most appropriate settings. Please see Tab 4 for an example of such material distributed to prospective residents at Broadmead.

Broadmead initiates discharge planning on admission as part of its development of the Resident Care Plan. Tab 5 includes Broadmead's Discharge Planning Policy.

Broadmead permits access to the facility for all Olmstead efforts approved by the Department of Health and Mental Hygiene to provide education and outreach for residents and their families.

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

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

Broadmead incorporates personal preference into daily living regardless of age. An interdisciplinary team develops an individualized program to connect residents with community services. Residents have access to technology, a calendar of campus events, magazines, reading materials, social media, music and more. Upon admission, a personalized plan of care is created based upon direct resident (or resident representative) feedback, circumstances, diagnosis and requests (which includes privacy for intimate needs). Activities are geared toward keeping residents as active and engaged as possible and affording them opportunities that are age appropriate and stimulating.

Broadmead offers the following community amenities: library, Café, gift shop, country store, video games (such as a Wii and personalized technologies), access to the pool and fitness center, a salon, cable television, and social events as well as access to outside patio space (accessible from the skilled nursing living area).

Broadmead offers a training program called "Person First" which covers a broad

spectrum to include the psychosocial needs of individuals under the age of 65 and addresses the combined influence that psychological factors and the surrounding environment have on the resident's physical and mental well-being and ability to function. Broadmead's staff is required to complete monthly on-line training programs that focus on the aging process and components of care and support. Residents have access to psychiatric and clinical social work services. Individual support and education is offered as needed or requested.

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

Discharge planning begins upon admission. Goals are identified upon admission and incorporated into the personalized rehabilitation program based upon an individualized assessment. Each resident (and or resident representative) receives information on the safest discharge recommendation based upon inpatient therapy observation. Home safety evaluations are incorporated into the discharge plan as needed or requested. Broadmead's connection with community-based programs also facilitates discharge in drawing upon these resources to assist residents with an earlier release. Residents are provided appropriate education and resources to support a person centered decision surrounding a discharge plan. Referrals to other providers or requested settings are shared and supported as early in the process as possible. A formal care plan meeting is scheduled by the 21st day post admission.

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

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

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

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

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

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

Broadmead is already served by a public water System.

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

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

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

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

The household model for skilled nursing care was chosen because it provides a person-centered approach that helps the resident transition from a traditional family home environment to an environment that is set up in a similar manner, to create a genuine home atmosphere while providing seniors with opportunities to direct their own lives. Similar to the home environment, the residents have their own kitchen, dining and living areas with access to the outside.

The household model is resident directed and promotes staff, residents and families working together to create a meaningful experience within the household. Reshaping the physical environment makes the unit more home-like and provides a shared sense of purpose and friendship.

Steve Shields and LaVrene Norton wrote about the household model in their book, *In Pursuit of the Sunbeam*, and provided the essential elements of the household model explaining the elements that make it a success. These elements are:

1. The household is each resident's home and sanctuary.
2. The people who live here direct their own lives, individually and collectively.
3. The boundaries of the person and his/her home are clear and respected as a matter of course.
4. Grace, a shared sense of what is sacred about the household and its people, is deeply valued, consciously created and preserved. Ritual, spontaneity, friendship, spirituality, celebration, recreation, choice, interdependence, art, and humor are all manifestations of a culture of grace.

5. The people who live here are loved and served by a responsive, highly valued, decentralized, self-led service team that has responsibility, authority, and accountability.
6. Leadership is a characteristic, not a position. Leaders support and are supported by values-driven, resource-bearing principles and practices as a way for each person to actualize his or her full potential.
7. All systems, including treatments, exist to support and serve the person within the context of his or her life pursuits.
8. We build strong community with one another, our family, neighbors, and town. Each household is part of a neighborhood of households, dedicated to continuous learning.
9. The physical building and all its amenities are designed to be a true home. Institutional creep in design and culture is treated as a wolf at the door.
10. The establishment of a healthy and sustainable home comes through the integrated balance of resident-driven life, leadership, organizational structure, physical environment and financial sustainability.[3]

Steven Proctor, CEO, Presbyterian Senior Living, wrote an article about the household model of care which seeks to create a tailored, more home-like environment for seniors. He notes that the person-centered model of care allows seniors to create their own schedules instead of shaping their lives around a schedule set by the provider. He further states that positive behavior is seen in smaller groups with individuals often becoming more outgoing and confident. In addition, he comments upon the transformation of leadership which supports a model that allows for staff empowerment to make decisions in the moment to benefit the persons served.[4]

The household model focuses on a home-like atmosphere where people can interact with others and share in activities; take a walk outside and enjoy the day; or return to their room to participate in personal enjoyment activities of reading, watching TV, etc.

To implement the organizational strategic goals of providing exceptional senior living services, superior healthcare to our residents, and establishing and maintaining a person-centered culture that respects the independence, choice and dignity of each individual, Broadmead commissioned RLPS Architects to provide design solutions for renovating its existing healthcare center to enhance comprehensive care, rehabilitation services and care for residents with dementia. The end goal is a warm and welcoming homelike environment to better facilitate person-centered care in all areas and establish a dedicated physical space to support a Center of Excellence in dementia care. The design solution utilizes modest additions in combination with interior renovations to

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[3] *In Pursuit of the Sunbeam, A Practical Guide to Transformation from Institution to Household,* Steve Shields and LaVrene Norton, authors, Action Pact, Incorporated, Jan. 1, 2006.

[4] *Transforming communities with the household model of care*, *McKnight's,* Steven Proctor, author, April 25, 2014. Mr. Proctor oversees senior living communities in Maryland, Delaware, Pennsylvania and Ohio.

effect the desired culture change in the delivery of care and improve quality of life for Broadmead residents who are no longer able to live independently.

Enhancing the quality of life of residents in long-term care settings is as important a goal as improving the quality of care and the safety and health of residents (Kane, 2001). According to The Center for Health Design, several studies show that different aspects of the physical environment—such as the unit layout, supportive features and finishes, reduced noise, as well as access to outdoor spaces—may be linked to better outcomes, including improved sleep, better orientation and wayfinding, reduced aggression and disruptive behavior, increased social interaction and communication and increased overall satisfaction and well-being. The design concept for the Broadmead care center is based on the following specific programming goals to best serve the needs of the resident population.

1. Create Neighborhood Settings by Program Area (Household Model)

To support the operational shift to resident-centered care, the design concept reorganizes the existing institutional nursing units into smaller residential-styled households that are defined by a grouping of resident rooms, each with its own living and dining areas. Household identities will be reinforced through a variety of interior finish material and color selections.

The conceptualization of the Household/Neighborhood Model for skilled nursing facilities began in 1987 at Evergreen Retirement Community in Oshkosh, Wisconsin. The model was validated through a year-long evaluative research study (Kalies, 1993). LaVrene Norton and Action Pact defined and articulated a specific philosophy and values for the Household Model. In 1997, the first households using the Action Pact model opened at Northern Pines (now Bigfork Valley) in Bigfork, MN.

The reinvented households will facilitate primary care staffing assignments to foster improved personal relationships between residents and staff members. The new open floor plan concept relocates staff areas from the center of activity to function behind the scenes. In the place of the former "command center," a new open living and open dining area provide familiar, comfortable spaces for residents to connect and enjoy their day. A cross-sectional survey of 1,194 employees and 1,079 relatives of residents in 107 residential-home units and health-center bed wards found that large unit size was related to increased time pressure among employees and reduced quality of life for residents (Pekkarinen, et al., 2004). Other studies found that small unit sizes were positively associated with increased supervision and interaction between staff and residents in a special-care unit for residents with dementia (McCracken & Fitzwater, 1989). Physical design changes in long-term care settings such as interior design modifications, natural elements, furniture repositioning to support social interaction, design supports for resident independence (such as large clocks, handrails, additional mirrors) and orientation (large, clear signposts and reality orientation boards), and artwork have been related to improved morale and satisfaction among staff

(Christenfeld, et al., 1989; Cohen-Mansfield & Werner, 1998; Cox, Burns, & Savage, 2004; Jones, 1988; Parker et al., 2004).

2. Provide a central living and dining room areas with access to natural light in each neighborhood.

The renovated households support Broadmead's commitment to provide person-centered care. The creation of open living and dining areas with kitchens will serve as a catalyst for implementing culture change in residents' daily lives. The living spaces will be improved by smaller scale individual spaces and updated residential furnishings to provide a more appealing and residentially-inspired atmosphere in which to enjoy life. The kitchens in particular will enable Broadmead to offer flexible dining, accommodate resident preferences, help to stimulate appetites through the sight and smell of food preparations and provide improved quality of meals.

The challenges of malnutrition, dehydration and weight loss in long-term care institutions is well documented, including landmark research in 2000 by Burger, Kayser-Jones and Bell. Not only can malnutrition and dehydration result in hospital admission, they also contribute to a decreased quality of life, morbidity, and mortality. In addition to these physiological, psychological, and pathological consequences, nursing home residents who do not receive adequate nutrition and hydration during the last months or years of their lives are denied one of life's greatest pleasures—the enjoyment of food and drink of their choice in a pleasant, social environment. Two of the nine specific recommendations in the 2000 study are uniquely descriptive of a neighborhood or household model, such as the provision of homelike surroundings at mealtime, smaller social neighborhoods, attractive food, choice in food, attention to ethnically sensitive/appropriate food choices, and making foods available 24 hours a day. Among their conclusions: "Some nursing homes have already discovered that creating small neighborhoods within larger nursing units to increase the social aspects of dining, and instituting cross-training of other nursing home staff to help at mealtimes are effective in preventing malnutrition and dehydration." (Burger, Kayser-Jones, and Bell, 2000). Other studies have shown that a non-institutional dining-room atmosphere was related to increased food intake among dementia residents (Evans & Crogan, 2001; Melin & Gotestam, 1981; Reed, Zimmerman, Sloane, Williams, & Boustani, 2005).

Another design priority, was introducing more natural light into living areas and providing access to outdoor spaces. The proposed design concept adds window seats in resident rooms overlooking new courtyard areas and relocates staff areas to the core so that both private and common living spaces benefit from windows and outdoor views. Numerous studies led by Roger Ulrich, PhD, EDAC, have demonstrated the value of natural light and views, perhaps most notably an early study of patients recovering from gallbladder surgery at Paoli Hospital outside of Philadelphia, Pennsylvania. Ulrich and his colleagues demonstrated that patients with a view of trees required less pain medications and on average were released from the hospital a day earlier than other patients in a room facing a brick wall (Ulrich 1984). A more recent study by Cornell University indicated that staff members who had access to natural light enjoyed

significantly lower blood pressure, communicated more often with colleagues, laughed more and served their patients in better moods than nurses who settle for large doses of artificial light. (Zadeh, et al, 2014)

3. Increase Privacy

The design converts approximately 80 percent of the existing semi-private units to private rooms. According to Calkins and Cassella in The Gerontologist (2007), there is strong evidence that as a general cohort, older adults overwhelming prefer private rooms over shared rooms. Patients feel they have better visits with families in a private room, and they express high satisfaction with this configuration (Chaudhury, et al, 2005; Ulrich & Zimring, 2004). Pergues and Woernle found that 84% of nursing home residents who developed acute nonbacterial gastroenteritis during an outbreak lived in a room with a roommate, whereas only 16% of residents who became ill lived in private rooms. Beyond the potentially life-threatening consequences, there are also significant cost implications of nosocomial infections in nursing homes, which were estimated in one study to be in the range of $1 billion. (Kayser-Jones, Wiener Barbacia, 1989)

Although we were unable to provide exclusively private rooms, the design concept includes measures to enhance privacy between residents sharing a room. Believing that privacy is defined to include acoustic privacy and that a cubicle curtain is insufficient, the design introduces a wall with a window between the two beds in a number of semi-private rooms to provide a higher level of privacy while maintaining natural light. While Calkins acknowledges that studies are lacking regarding the impacts of this type of measure for an enhanced shared room configuration (Calkins & Cassella, 2007), post occupancy review by RLPS Architects have indicated that this solution has been well received (by residents formerly living in a traditional semi-private hospital configuration) and, in some cases, provided an unexpected benefit of appealing to couples who rearranged the room to function as separate living and bedroom areas.

Forty-four percent of the residents from semiprivate rooms reported going to social spaces when visitors came to visit them (Pinet, 1999). Therefore, each household also includes a private parlor and sitting areas to accommodate family visits or private meetings.

4. Increase Bathing Within Rooms

The design concept converts all the resident toilet rooms to bathrooms that allow for in-room bathing. Culture change in the nursing care industry is suggesting that a resident centered approach would provide the opportunity to bathe in the resident's own private bathroom rather than a central bathing room (Brawley, 2002; Calkins, 2007). Based on case study articles and expert opinion (Sloane & Carnes, 2008), it is recognized that showering is the most common bathing method used by U.S. adults, including person in long term care. MDS survey data suggests 65% of residents prefer showers while 35% prefer baths. The design concepts incorporate safety features for both staff and residents, such as fold-down grab bars and curb-less showers to provide

a pleasant and dignified bathing and toileting environment. The design is based on a white paper proposal for additions to accessibility standards for Nursing Home & Assisted Living residents in toileting and bathing prepared by The American Institute of Architects Design for Aging Knowledge Community Task Force. The design concept introduces zero-threshold, roll-in showers within residentially finished and scaled bathrooms. The European showers enable residents to bathe more independently within the privacy of their room, with staff functioning in a support role as needed. The European showers also provide a generous turning radius, based on Task Force recommendations to accommodates wheelchairs, lifts and broda chairs. Fold-down grab bars are appropriately located and sized, enabling residents to properly bend their elbows and bear more weight for more independent toileting. The remaining spa rooms for residents who prefer or require tub bathing, will be redesigned to provide a more tranquil spa experience.

5. Enhance Levels of Care to Serve a More Diverse Population

Broadmead has entered into a collaborative engagement with Johns Hopkins HealthCare, LLC to develop a program that combines current best practices in dementia care with forward-thinking approaches and evidence-based research. This collaborative program supports the Johns Hopkins Medicine mission of being at the forefront of discovery and patient-centered care. For the dementia care center of excellence, the team will develop a program that combines current best practices in dementia care with forward-thinking approaches and evidence-based research. The facility design to support the resulting programs provides dedicated skilled care and assisted living memory support neighborhoods with access to outdoor space, and in the case of assisted living, a secure terrace garden. A few studies have shown that providing access to safe outdoor spaces as an alternative to prevent exiting, generated positive outcomes such as reduced agitation among dementia residents (Mooney & Nicell, 1992; Namazi & Johnson, 1992).

The decision to provide a dedicated household for individuals with dementia reflects a philosophical change in direction for Broadmead. The impetus for a specialized residence has been a combination of resident issues, safety concerns and family member preferences, as well as research illustrating the advantages of a specialized environment that respects the value of each individual and accommodates independence and self-expression to the greatest extent possible. The design of a specialized household allows for integration of the Alzheimer's Association's Dementia Care Practice Recommendations related to the environment such as developing a walking path that encourages exploration and strolling with points of interest that encourage visual and tactile stimulation. According to the Alzheimer's Association, resident functioning can improve when the environment minimizes distractions that can frighten or confuse residents, while maximizing environmental factors that promote independence. Designing to promote spatial orientation and wayfinding are critical in environments for persons with dementia who commonly suffer from disorientation—confusion regarding place, time, personal identity, and social situation (Calkins, 2001; Cohen & Day, 1991; Day, Carreon, & Stump, 2000). In addition to variations to interior

finishes to help residents distinguish household areas including their own room, the design also introduces memory boxes outside each resident room for personal effects to assist with wayfinding and staff relationships with residents. Systematic research has demonstrated that items that had greater personal significance—whether photos or trinkets—did help most residents find their rooms more independently (Namazi, Rosner & Rechlin, 1991).

The design also includes a dedicated rehab neighborhood with direct access to the physical therapy area. The new rehab neighborhood can be easily accessed without the need to go through other skilled nursing areas and includes all private rooms. Social spaces, including dining, are minimized, based on post occupancy evaluations by RLPS indicating that most patients prefer to remain in the privacy of their rooms during a short-term stay in a rehabilitation area. All areas will be upgraded to reflect a residential design aesthetic. A study by Harris (2000) found that family and friends stayed substantially longer during visits to rehabilitation units when resident rooms were carpeted rather than covered with vinyl flooring.

The most influential driver to the project was Broadmead's vision and conviction to creating both a resident-centered care operation that focuses on the individual as a person and not as a diagnosis, and a supportive physical environment that embraces flexibility and resident self-determination, counter to the culture of dependence typical to institutional long term care. Architectural decisions to reinvent the environment were made based on establishing a functional program of creating a home that provides comfort, attachment, inclusion, identity, occupation and caring. Design decisions were based primarily on the ability to reinforce this functional objective and where they would have the most impact.

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

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

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

Broadmead has a transfer agreement with Edenwald Retirement Community and the Maryland Masonic Home, in the event of the need to admit a Broadmead Resident or an emergency situation requiring an evacuation our comprehensive care residents.

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

(1) Bed Need.

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

target population; utilization trends for the past five years and expected changes in the next five years; and demonstrated unmet needs of the target population.

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

Broadmead will use its current 70 licensed comprehensive care beds in the Commission's inventory, and will not be requesting an expansion of beds. The renovation of Broadmead's comprehensive care facility will restructure the existing institutional medical nursing home model to a person-centered, household model of care. The plan will result in four households of 13 or less residents, consistent staffing, and an increase in private room offerings with updated private bathrooms. Market research and Resident Satisfaction Surveys strongly reflect a desire and expectation of a person-centered model of care with updated amenities and private accommodations. This redesign and repositioning of Broadmead's comprehensive healthcare program is necessary to continue to meet the short term and long term healthcare needs of our residents.

The most recent MHCC Comprehensive Care Bed Need Projections for Baltimore County published by the MHCC (Maryland Register, 4/16/2016, p. 572) shows:

Gross Bed Need:	4,585
Total Bed Inventory:	5,496
Unadjusted Net Bed Need:	-911
Community Based Services Adjustment:	228
2016 Net Bed Need	0

As stated above, Broadmead is not seeking to add new nursing home capacity in Baltimore County. Furthermore, the projections are out of date, as they are for 2016.

As the bed need projections are out of date, Broadmead has extended the projection of bed need in Baltimore County to the year 2020 using the MHCC's methodology as described on pages 24-25 of the Long Term Care section of the State Health Plan. Broadmead's consultant, Andrew Solberg, had the base year 2008 data because they were provided to him in the matter of Blue Heron Nursing and Rehabilitation Center (Docket No. 13-18-2348).

Broadmead downloaded the most recent "2014 Household Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14)" from the Maryland Department of Planning website. We then aggregated the 2020 date for each jurisdiction for the age cohorts 0-64, 65-74, 75-84, and 85+, which are the cohorts used in the methodology.

Population
2020
By Jurisdiction

Jurisdiction	0-64	65-74	75-84	85+
ALLEGANY	59,871	8,273	4,913	2,091
ANNE ARUNDEL	488,054	56,050	26,262	9,632
BALT/CO	697,720	85,592	40,507	23,180
CALVERT	80,123	9,482	4,346	1,650
CAROLINE	30,136	3,629	1,630	655
CARROLL	143,662	19,473	9,131	3,632
CECIL	91,028	10,802	4,895	1,871
CHARLES	151,634	14,398	6,330	1,989
DORCHESTER	27,717	4,127	2,105	849
FREDERICK	223,315	24,434	12,025	5,876
GARRETT	24,014	3,808	2,035	738
HARFORD	214,207	25,971	12,279	6,191
HOWARD	282,207	30,513	14,750	4,783
KENT	15,515	3,311	1,754	819
MONTGOMERY	898,802	98,009	47,778	22,412
PR GEORGES	790,688	77,281	34,222	12,304
QUEEN ANNES	43,127	6,081	3,325	1,066
ST MARYS	108,517	9,749	5,064	1,818
SOMERSET	23,331	2,647	1,288	481
TALBOT	28,701	6,680	3,971	1,495
WASHINGTON	132,873	15,532	8,161	3,734
WICOMICO	90,967	10,590	5,186	2,455
WORCESTER	41,157	8,305	4,864	1,774
BALT/CITY	552,808	49,379	22,194	9,711

Source: Maryland Department of Planning, (http://www.mdp.state.md.us/msdc/S3_Projection.shtml), Accessed 3/7/17.

The methodology follows the following steps.

1. *Calculate the base year patient days by age group, area of origin, and jurisdiction of care.*

This step was already performed by MHCC staff in the data provided to Mr. Solberg.

2. *Calculate the base year use rate by age group by applying the following rules:*

    a. *Calculate the use rate for the most recent year, by age group and jurisdiction of origin, by dividing the base year patient days, by age*

group and Maryland jurisdiction of origin, by the base year population, by age group and jurisdiction of origin, and multiplying the result by .1.000.

b. Calculate an adjusted base year use rate by reducing the base year use rate calculated in Paragraph (a) above by 5 percent.

This step also was already performed by MHCC staff in the data provided to Mr. Solberg.

3. Calculate the target year patient days for each age group for each Maryland jurisdiction of residence by multiplying the adjusted base year use rate for a given age group in the jurisdiction of residence by the target year projected population for the same age group in the jurisdiction, and dividing the result by 1,000.

Broadmead made this calculation by multiplying the appropriate use rate times the appropriate population in each jurisdiction.

4. Calculate the migration-adjusted target year patient days for each jurisdiction of care by using the following rules:

(a) When the jurisdiction of residence is the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, add the base year patient days for a given age group, receiving care in the same jurisdiction of residence, to one half of the base year patient days for a given age group receiving care outside the jurisdiction of residence; divide the result by the base year patient days for the age group and jurisdiction of residence; multiply by the target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence in Maryland;

(b) When the jurisdiction of residence in Maryland is not the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, divide the base year patient days for a given age group, a given jurisdiction of residence, and a given jurisdiction of care by twice the base year patient days for the age group and the jurisdiction of residence; multiply the result by the target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence;

(c) When the retention rate is greater than 80 percent, or the base year use rate for the 65+ population is less than the 33rd percentile, the target year patient days are equal to the patient days for each jurisdiction of residence as calculated in step 4(a); sum the result over all jurisdictions of residence;

(d) When the jurisdiction of residence is an adjacent state, sum the base year patient days for each age group and jurisdiction of residence for a given

jurisdiction of care, multiply the base year patient days for each age group by the population growth rate in that age group, and sum the result over all jurisdictions of residence for a given jurisdiction of care.

The data provided to Mr. Solberg identified which Step 4 rules applied to each age cohort from each jurisdiction of residence and each jurisdiction of care. Broadmead applied the appropriate step as identified by the MHCC.

However, for persons who received care in Baltimore County from Out of State, Broadmead simply used the 2008 volumes and assumed no growth.

5. *Calculate the total target year patient days for each jurisdiction of care by summing the target year patient days for each age group in the jurisdiction of care over all age groups,*

Broadmead calculated that the total number of patient days that would be experienced in Baltimore County in 2020 is 1,769,011.

6. *Calculate the gross bed need for each jurisdiction of care by dividing the target year patient days for the jurisdiction by the product of365 and 0.95.*

Total 2020 Patient Days	1,769,011
ADC	4,847
Occupancy	0.95
Beds	5,102

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

On 3/13/17, Kevin McDonald, Chief - Certificate of Need Division at the MHCC provided Broadmead with an updated nursing home bed inventory, showing that there are 5,465 licensed, waiver, and temporarily de-licensed beds in Baltimore County.

Needed Beds, 2020	5,102
Total Beds	5,465
Net Need	(363)

8. *Calculate the number of nursing home beds for which community based services (CBS) will substitute in each jurisdiction of care.*
   (a) Calculate the proportion of total nursing home patient days represented by the patients appropriate for CBS by dividing the CBS days by the total patient days for each jurisdiction of care in the base year.

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

(c) *Calculate the number of nursing home beds for which CBS will substitute for nursing home beds in each jurisdiction of care by dividing the target year patient days appropriate for CBS by the result of the product of365 and 0.95.*

According to the data that the MHCC had provided to Mr. Solberg, the CBS percentage for Baltimore County used in the current projections was 4.96%.

CBS Adj.	4.96%
Total 2020 Patient Days	1,769,011
CBS Pt. Days	87,787
ADC	241
Occupancy	0.95
CBS Bed Adjustment	253

9. *Calculate the adjusted net bed need for each jurisdiction of care by subtracting the number of nursing horne beds for which CBS will substitute from the net bed need for each jurisdiction of care.*

Needed Beds, 2020	5,102
Total Beds	5,465
Net Need	-363
CBS Bed Adjustment	253
Total 2020 Need	-616

Broadmead recognizes that the MHCC methodology still shows a bed excess in Baltimore County. The point of presenting this is that these projections show that, compared to the "current" MHCC bed need projections for 2016, people will need 523 additional beds than were projected for 2016. That constitutes a substantial reduction in the bed excess. Broadmead's project will do nothing to add to the excess.

	2020	2016	Difference
Gross Need (Beds)	5,102	4585	
Total Beds	5,465	5496	
Net Need	-363	-911	
CBS Bed Adjustment	253	228	
Total 2020 Need	-616	-1139	-523

(2) Facility Occupancy.

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

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

Not applicable. Broadmead is not increasing its beds.

(3) Jurisdictional Occupancy.

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

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

Not applicable. Broadmead is not a new nursing home.

(4) Medical Assistance Program Participation.

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

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

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

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

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

Please see the response to 10.24.08.05.A(2).

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

Broadmead has no outstanding Level G or higher deficiencies and has a 5-star CMS rating. Broadmead maintains a demonstrated program of quality assurance. Tab 6 includes Broadmead's Quality Assurance Policy.

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

Not applicable. This is not a relocation project.

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

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

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

All of Broadmead's beds remain in good standing.

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

Broadmead has no outstanding Level G or higher deficiencies.

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

(a) Shall participate in the Medicaid Program;

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

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

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

Please see the response to 10.24.08.05.A(2).

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

The existing skilled nursing units are nearly forty years old. It was constructed in a time when the philosophy of nursing unit design was very different and included predominantly semi-private rooms and a long single corridor. Since then the culture of long term care has changed, based on improvements in both quality of life and quality of care.

As stated previously, one aspect of the skilled nursing project involves converting a 40 bed skilled nursing unit into two households of clusters of 10 and 13 rooms respectively. Except for four resident rooms that are designed to be shared with a private bathroom, resident rooms will be private and have a private bathroom. In addition, each household will promote the social model of care and contain dining, an activity kitchen and social spaces organized around an exterior courtyard. The courtyard will provide access to outdoors and natural light.

An 11 room (13 bed) skilled nursing household will be developed to meet the needs of residents with a diagnosis of dementia. This does not currently exist at Broadmead. The residents will be provided with dining, an activity kitchen, social spaces and direct access to a secure outdoor courtyard. Two of the rooms will be designed to accommodate couples while the other rooms will be private.

An 11 room (13 bed), traditional skilled nursing household will be provided with dining, an activity kitchen and social spaces. Two of the rooms are designed to be shared to accommodate couples. This neighborhood is in a proposed addition expanding the existing health center building and will be located on the third floor.

A 17 bed rehabilitation household will be developed as part of the skilled nursing project. This household will be designed to center on the needs of residents seeking short-term rehabilitation services, and will include dining and social spaces appropriately sized for this short-term population. This rehabilitation household will have direct elevator access to the recently renovated physical therapy gym. All resident rooms will be private with private bathrooms.

As explained previously, the household model for skilled nursing care was chosen because it provides a person-centered approach that helps the resident transition from a traditional family home environment to an environment that is set up in a similar manner, to create a genuine home atmosphere while providing seniors with opportunities to direct their own lives. Similar to the home environment, the residents

have their own kitchen, dining and living areas with access to the outside.

The household model is resident directed and promotes staff, residents and families working together to create a meaningful experience within the household. Reshaping the physical environment makes the unit more home-like and provides a shared sense of purpose and friendship.

The household model focuses on a home-like atmosphere where people can interact with others and share in activities; take a walk outside and enjoy the day; or return to their room to participate in personal enjoyment activities of reading, watching TV, etc.

10.24.01.08G(3)(b). Need.

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

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

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

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

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

This project will involve modernization of Broadmead's existing 70 bed comprehensive care facility through renovation and expansion of the current building in order to reduce the number of semi-private rooms and increase the number of private

rooms, while also enhancing common spaces. Through a market analysis conducted by Love and Company, as of February, 2014, and a Resident Satisfaction Survey conducted by Holleran in 2013, our stakeholders have communicated the preference of an updated comprehensive care facility with more private accommodations. This restructure and design will support a person-centered, household model of care with the ability to provide consistent staff assignments and family-style household programming and culture. The local hospitals and residents of the local surrounding communities have shown an increased interest in Broadmead's short term rehabilitation program. The number of short term admissions has increased from an average of two per day prior to 2013, to an average of 8 per day in 2017, and projected utilization of 15 per day by 2020. This renovation project will include a dedicated short term rehabilitation household that will be attractive to older adults who have been discharged from an acute hospital stay, and are in need of rehabilitation therapies.

Broadmead's comprehensive care building is over 35 years old. The current building structure supports an antiquated, institutional, medical model of care. The lighting and heating/cooling systems will be upgraded to more energy efficient systems. The master plan design for the renovation of the comprehensive care facility will bring Broadmead back in compliance regarding the number of bathing rooms required under COMAR 10.07.02.28.D.8.

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

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

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

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

The Executive Leadership team along with the Board of Trustees and Residents embarked on developing a comprehensive and progressive strategic plan for the 36 year old Broadmead community. As a result of multiple market studies, a Resident Satisfaction Survey, an Employee Satisfaction Survey, and engaging stakeholders in focus groups, four key organizational strategic goals were identified:

Goal 1. Provide Exceptional Senior Living Services and Superior Healthcare to our Residents;

Goal 2. Establish and Maintain a Person-Centered Culture that Respects the Independence, Choice and Dignity of Each Individual;

Goal 3. Create Centers of Excellence in Programs and Environments in Senior Living and Healthcare; and

Goal 4. Expand programs, on and off the Broadmead Campus, to a population of older adults more reflective of the economic levels and socio-cultural demographics of the mid-Atlantic region.

A Master Plan was created to support these four organizational strategic goals through repositioning and renovating the campus. The Master Plan includes the following proposed projects for Broadmead's Healthcare residents:

A. Creation of dedicated space to support a Center of Excellence for Health and Wellness, through the renovation of vacated Independent Living apartments;
B. Addition of a new Memory Support Assisted Living household, with 14 new licensed AL beds;
C. Maximize the number of private rooms with in-room bathing;
D. Create neighborhood settings by program area (household model)
    1. Household for rehabilitation residents,
    2. Household for residents with a diagnosis of dementia,
    3. Two households for long-term care residents; and
E. Enhance levels of care to serve a more diverse population.

Several approaches for addressing the master plan goals were investigated. They are the following:

Option A - Remodel of the existing nursing home.

The existing floor plans would remain with minor remodeling and new finishes would be provided throughout the nursing area.

The existing facility consists of mostly of semi-private resident rooms without in-room bathing (central bathing). The rooms are located in two large areas layout out in a traditional healthcare (institutional) setting. There is one large dining room to serve the residents. This option did not achieve the goals or objectives of the master plan

because the resident rooms would remain mostly shared, no distinct households would exist, and one large dining venue would serve residents. This option would not support the goal of achieving person-centered lifestyle and engagement programming, or consistent caregiver assignments.

Option B - Renovation of the existing nursing home.

The exiting healthcare areas would be fully renovated with a new floor plan and finishes.

The existing facility consists of mostly semi-private resident rooms without in-room bathing (central bathing). Once resident rooms were converted to private rooms with in-room bathing, the total number of beds would be reduced almost in half, which would not allow servicing of Broadmead residents. The rooms are located In a layout of two large areas laid out in a traditional healthcare (institutional) setting. The one large dining room to serve the residents would remain. This option did not achieve the goals or objectives of the master plan because the number of resident rooms would not be enough to support operations, no distinct households would exist, and one large dining venue would serve residents.

Option C – All new nursing Home.

A new facility would be built to accommodate the master plan programs and goals. The cost for a new facility's construction was estimated to be in the neighborhood of $12,862,000 for a 70 bed facility. The entirely new facility was determined to be not feasible. The land necessary to build the facility was not available on campus.

Option D – Full Renovation of the existing nursing home with additions.

The exiting healthcare areas would be fully renovated with a new configuration and finishes. Two additions would be added to accommodate the private rooms, households, and dining venues. This option requires additional square footage than the existing nursing area has. Additions will be added to increase the area to meet the program of the master plan.

Option D was determined to be the option that met the requirements of the master plan with the least cost. The renovation and new construction project will include the development of four households of traditional nursing clusters, one of which will be dedicated to the support of residents in the later stages of dementia. Each household will be provided with dining, an activity kitchen and social spaces. Two of the households will have direct access to an exterior courtyard. In addition, 17 of the 70 licensed skilled beds will be dedicated for a short term rehabilitation household. This household will have all private rooms with private bathrooms and European showers, ample dining and living room space, and direct elevator access to the physical therapy gym.

Option D will support the strategic goal of creating a culture of person-centered, individualized care and services. Meal plans, lifestyle events, holiday recognition, and other traditions can all be individualized for each household, based on the preferences of the residents. Each resident will reside in a household where they will have consistent caregivers and, where they can establish and engage in relationships with others who reside in their household.

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

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

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

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

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

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

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

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

As the CON Application Table Package shows, Broadmead is financially viable and will remain so after it implements this project.

Tab 7 includes Broadmead's most recent audited financial statement.

Tab 8 includes a letter expressing interest in working with Broadmead to obtain financing.

Tab 9 includes letters of support. As more are received, Broadmead will forward them to the MHCC.

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

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

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

Broadmead has no CONs within the last 15 years.

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

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

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified

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

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs to the health care delivery system.

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

This project will have little impact on any other facility. The beds are already in existence, and, while Broadmead projects a higher occupancy, the number of additional patient days are relatively small, and would not have a material impact on any single facility.

Most of the SNF referrals Broadmead receives are from UM St. Joseph Medical Center and Greater Baltimore Medical Center. Together, these hospitals have broad service areas, and any impact of increased referrals will be dispersed among many facilities. It will not impact the average countywide occupancy, as Broadmead's beds are counted in the countywide rate.

This project will increase access to new state of the art facilities, giving consumers a greater high quality choice of modern facilities.

TAB 2

CON TABLE PACKAGE

CON TABLE PACKAGE FOR NURS .G HOME (CCFs) APPLICATIONS

Name of Applicant: Broadmead, Inc.

Date of Submission: 7-Apr-17

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table	Table Title	Instructions
Table A	**Bed and Room Inventory**	All Comprehensive Care facility applicants must complete Table A regardless of the project type and scope.
Table B	**Construction and Renovation Square Footage**	All applicants proposing new construction or renovation must complete Table B.
Table C	**Project Budget**	All applicants, regardless of project type or scope, must complete Table C.
Table D	**Utilization - Entire Facility**	Existing facility applicants must complete Table D. All applicants who complete this table must also complete Table F.
Table E	**Utilization - New Facility or Service**	Applicants who propose to: establish a new facility; a new service; or are directed by MHCC staff must complete Table E. All applicants who complete this table must also complete Table G.
Table F	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table F. The projected revenues and expenses in Table F should be consistent with the volume projections in Table D.
Table G	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to: establish a new facility; a new service and any other applicant who completes a Table D must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table E.
Table H	**Workforce**	All applicants, regardless of project type or scope, must complete Table H.
Table I	**Bedside Care Staffing**	All applicants, regardless of project type or scope, must complete Table I.

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

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

Before the Project						After Project Completion				
		Based on Physical Capacity				Based on Physical Capacity				
		Room Count					Room Count			
Service Location (Floor/Wing)	Current Licensed Beds	Private	Semi-Private	Total Rooms	Physical Bed Capacity	Service Location (Floor/Wing)	Private	Semi-Private	Total Rooms	Physical Bed Capacity
COMPREHENSIVE CARE						COMPREHENSIVE CARE				
2nd floor LTC	70	40	15	55	70	*nd floor LTC Memory Suppor*	9	2	11	13
				0	0	*2nd floor Skilled LTC*	19	4	23	27
				0	0	2nd floor Rehab	17	0	17	17
				0	0	3rd floor Skilled	9	2	11	13
				0	0				0	0
SUBTOTAL Comprehensive Care	70	40	15	55	70	**SUBTOTAL**	54	8	62	70
ASSISTED LIVING						**ASSISTED LIVING**				
3rd floor AL	30	28	1	29	30	*3rd floor AL*	24	2	26	28
						2nd floor AL Memory Support	12	2	14	16
TOTAL ASSISTED LIVING	30	28	1	29	30	**TOTAL ASSISTED LIVING**	36	4	40	44
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*			0	0
TOTAL OTHER						**TOTAL OTHER**				
FACILITY TOTAL	100	68	16	84	100	**FACILITY TOTAL**	90	12	102	114

TABLE B. PROPOSED NEW CONSTRUCTION AND RENOVATION SQUARE FOOTAGE

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

Gross Square Footage by Floor/Nursing Unit/Wing	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
2nd Floor, SNF	11,751	2,705	11,751	0	14,456
2nd Floor, Rehab	8,646	0	8,646	0	8,646
2nd Floor, SN Dementia	5,159	2,422	5,159	0	7,581
3rd Floor, SNF	0	5,539	1,577	0	7,116
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	25,556	10,666	27,133	0	37,799

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 attechment 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	Other Service Areas	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$2,531,000	$11,437,000	$13,968,000
(2) Fixed Equipment	39,000	161,000	200,000
(3) Site and Infrastructure	339,000	3,647,000	3,986,000
(4) Architect/Engineering Fees	317,000	1,240,000	1,557,000
(5) Permits (Building, Utilities, Etc.)	28,000	237,000	265,000
SUBTOTAL New Construction	**$3,254,000**	**$16,722,000**	**$19,976,000**
b. Renovations			
(1) Building	5,650,000	20,662,000	26,312,000
(2) Fixed Equipment (not included in construction)	58,000	242,000	300,000
(3) Architect/Engineering Fees	471,000	1,972,000	2,443,000
(4) Permits (Building, Utilities, Etc.)	113,000	356,000	469,000
SUBTOTAL Renovations	**$6,292,000**	**$23,232,000**	**$29,524,000**
c. Other Capital Costs			
(1) Movable Equipment	720,000	1,580,000	2,300,000
(2) Contingency Allowance	580,000	2,345,000	2,925,000
(3) Gross interest during construction period	1,174,000	4,672,000	5,846,000
(4) Other *(Specify/add rows if needed): Development Costs*	575,000	500,000	1,075,000
Pre-Development Costs	200,000	100,000	300,000
Marketing Costs	-	1,765,000	1,765,000
SUBTOTAL Other Capital Costs	***$3,249,000***	***$10,962,000***	**$14,211,000**
TOTAL CURRENT CAPITAL COSTS	**$12,795,000**	**$50,916,000**	**$63,711,000**
d. Land Purchased/Donated			
e. Inflation Allowance	-	-	-
TOTAL CAPITAL COSTS	**$12,795,000**	**$50,916,000**	**$63,711,000**
Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	473,000	2,092,000	2,565,000
b. Bond Discount	-	-	-
c. Legal Fees CON)	50,000	-	50,000
d. Legal Fees (Other)	-	50,000	50,000
e. Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON	25,000	-	25,000
f. Non-Legal Consultant Fees	284,000	426,000	710,000
g. Liquidation of Existing Debt	-	5,448,000	5,448,000
h. Debt Service Reserve Fund	1,065,000	4,858,000	5,923,000
i. Other *(Specify/add rows if needed):*	-	-	-
SUBTOTAL	***$1,897,000***	***$12,874,000***	**$14,771,000**
3. Working Capital Startup Costs	$31,000	$15,000	$46,000
TOTAL USES OF FUNDS	***$14,723,000***	***$63,805,000***	***$78,528,000***
B. Sources of Funds			
1. Cash	186,000	822,000	1,008,000
2. Philanthropy (to date and expected)	-	-	-
3. Authorized Bonds	14,537,000	62,983,000	77,520,000
4. Interest Income from bond proceeds listed in #3	-	-	-
5. Mortgage	-	-	-
6. Working Capital Loans	-	-	-
7. Grants or Appropriations			
a. Federal	-	-	-
b. State	-	-	-
c. Local	-	-	-
8. Other *(Specify/add rows if needed)*		-	-
TOTAL SOURCES OF FUNDS	***$14,723,000***	***$63,805,000***	**$78,528,000**
Annual Lease Costs (if applicable)			
1. Land	-	-	-
2. Building	-	-	-
3. Major Movable Equipment	-	-	-
Minor Movable Equipment	-	-	-
5. Other *(Specify/add rows if needed)*	-	-	-

* 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 D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

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

				2018	2019	2020	2021	2022	2023	2024
	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY = FY	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
1. ADMISSIONS										
a. Comprehensive Care (public)	68	63	95	71	70	51	72	82	83	83
b. Comprehensive Care (CCRC Restricted)	60	45	28	40	40	30	47	49	49	49
Total Comprehensive Care	**128**	**108**	**123**	**110**	**110**	**81**	**119**	**131**	**131**	**131**
c. Assisted Living	11	8	8	8	9	12	11	12	12	12
d. Other (Specify/add rows of needed)										
TOTAL ADMISSIONS	***139***	***116***	***131***	***118***	***119***	***93***	***129***	***143***	***143***	***143***
2. PATIENT DAYS										
a. Comprehensive Care (public)	2,734	4,162	4,775	7,775	7,702	5,658	7,921	9,052	9,089	8,870
b. Comprehensive Care (CCRC Restricted)	16,122	15,564	14,975	11,936	12,009	8,943	13,980	14,673	14,637	14,856
Total Comprehensive Care	**18,856**	**19,726**	**19,750**	**19,710**	**19,710**	**14,600**	**21,900**	**23,725**	**23,725**	**23,725**
c. Assisted Living	9,302	9,494	9,494	9,490	10,945	14,600	12,812	14,229	14,235	14,235
d. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***28,158***	***29,220***	***29,244***	***29,200***	***30,655***	***29,200***	***34,712***	***37,954***	***37,960***	***37,960***
3. NUMBER OF BEDS										
a. Comprehensive Care (public)	70	70	70	70	70	70	70	70	70	70
b. Comprehensive Care (CCRC Restricted)	0	0	0	0	0	0	0	0	0	0
Total Comprehensive Care Beds	**70**	**70**	**70**	**70**	**70**	**70**	**70**	**70**	**70**	**70**
c. Assisted Living	30	30	30	30	34	44	44	44	44	44
d. Other (Specify/add rows of ne										
TOTAL BEDS	***100***	***100***	***100***	***100***	***104***	***114***	***114***	***114***	***114***	***114***
4. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	10.7%	16.2%	18.7%	30.4%	30.1%	22.1%	31.0%	35.4%	35.6%	34.6%
b. Comprehensive Care (CCRC Restricted)	63.1%	60.7%	58.6%	46.7%	47.0%	34.9%	54.7%	57.4%	57.3%	58.0%
Total Comprehensive Care Beds	**73.8%**	**77.0%**	**77.3%**	**77.1%**	**77.1%**	**57.0%**	**85.5%**	**92.9%**	**92.9%**	**92.6%**
c. Assisted Living	84.9%	86.7%	86.7%	86.7%	88.2%	90.7%	79.8%	88.6%	88.6%	88.4%
d. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**77.1%**	**80.1%**	**80.1%**	**80.0%**	**80.8%**	**70.0%**	**83.4%**	**91.2%**	**91.2%**	**91.0%**
5. OUTPATIENT (specify units used for charging and recording revenues)										
a. Adult Day Care										
b. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. (IZATION PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY = FY	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
1. ADMISSIONS							
a. Comprehensive Care (public)	71	70	51	72	82	83	83
b. Comprehensive Care (CCRC Restricted)	40	40	30	47	49	49	49
Total Comprehensive Care	**110**	**110**	**81**	**119**	**131**	**131**	**131**
c. Assisted Living	8	9	12	11	12	12	12
d. Other (Specify/add rows of needed)							
TOTAL ADMISSIONS	***118***	***119***	***93***	***129***	***143***	***143***	***143***
2. PATIENT DAYS							
a. Comprehensive Care (public)	7,775	7,702	5,658	7,921	9,052	9,089	8,870
b. Comprehensive Care (CCRC Restricted)	11,936	12,009	8,943	13,980	14,673	14,637	14,856
Total Comprehensive Care	**19,710**	**19,710**	**14,600**	**21,900**	**23,725**	**23,725**	**23,725**
c. Assisted Living	9,490	10,945	14,600	12,812	14,229	14,235	14,235
TOTAL PATIENT DAYS	***29,200***	***30,655***	***29,200***	***34,712***	***37,954***	***37,960***	***37,960***
3. NUMBER OF BEDS							
a. Comprehensive Care (public)	70	70	70	70	70	70	70
b. Comprehensive Care (CCRC Restricted)	0	0	0	0	0	0	0
Total Comprehensive Care Beds	**70**	**70**	**70**	**70**	**70**	**70**	**70**
c. Assisted Living	30	34	44	44	44	44	44
d. Other (Specify/add rows of needed)							
TOTAL BEDS	***100***	***104***	***114***	***114***	***114***	***114***	***114***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. Comprehensive Care (public)	30.4%	30.1%	22.1%	31.0%	35.4%	35.6%	34.6%
b. Comprehensive Care (CCRC Restricted)	46.7%	47.0%	34.9%	54.7%	57.4%	57.3%	58.0%
Total Comprehensive Care Beds	**77.1%**	**77.1%**	**57.0%**	**85.7%**	**92.9%**	**92.9%**	**92.6%**
c. Assisted Living	86.7%	88.2%	90.7%	79.8%	88.6%	88.6%	88.4%
d. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**80.0%**	**80.8%**	**70.0%**	**83.4%**	**91.2%**	**91.2%**	**91.0%**
5. OUTPATIENT (specify units used for charging and recording revenues)							
a. Adult Day Care							
b. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY = FY	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
1. REVENUE										
a. Inpatient Services	$ 17,641,000	$ 19,158,000	$ 19,644,000	$ 19,541,000	$ 19,396,000	$ 19,861,000	$ 24,147,835	$ 26,168,372	$ 26,227,172	$ 26,317,504
b. Outpatient Services										
Gross Patient Service Revenues	***$ 17,641,000***	***$ 19,158,000***	***$ 19,644,000***	***$ 19,541,000***	***$ 19,396,000***	***$ 19,861,000***	***$ 24,147,835***	***$ 26,168,372***	***$ 26,227,172***	***$ 26,317,504***
c. Allowance For Bad Debt										
d. Contractual Allowance							$ 394,000	$ 532,000	$ 532,000	$ 532,000
e. Charity Care										
Net Patient Services Revenue	***$ 17,641,000***	***$ 19,158,000***	***$ 19,644,000***	***$ 19,541,000***	***$ 19,396,000***	***$ 19,861,000***	***$ 23,753,835***	***$ 25,636,372***	***$ 25,695,172***	***$ 25,785,504***
f. Other Operating Revenues (Specify/add rows if needed)										
Amortization of entrance fees	$ 4,661,000	$ 4,742,000	$ 4,610,000	$ 4,748,000	$ 4,891,000	$ 6,052,000	$ 7,260,000	$ 7,416,000	$ 7,576,000	$ 7,742,000
Investment income	$ 1,572,000	$ 1,015,000	$ 779,000	$ 846,000	$ 1,015,000	$ 1,229,000	$ 1,345,000	$ 1,289,000	$ 1,294,000	$ 1,303,000
Other	$ 1,440,000	$ 1,107,000	$ 1,126,000	$ 1,126,000	$ 1,126,000	$ 1,138,000	$ 1,209,000	$ 1,233,000	$ 1,237,000	$ 1,241,000
NET OPERATING REVENUE	***$ 25,314,000***	***$ 26,022,000***	***$ 26,159,000***	***$ 26,261,000***	***$ 26,428,000***	***$ 28,280,000***	***$ 33,567,835***	***$ 35,574,372***	***$ 35,802,172***	***$ 36,071,504***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 7,922,000	$ 8,224,000	$ 8,347,000	$ 8,407,000	$ 8,454,000	$ 8,343,000	$ 8,806,000	$ 9,536,000	$ 9,536,000	$ 9,536,000
b. Contractual Services										
c. Interest on Current Debt	109,000	140,000	146,000	149,000	55,000	78,000	276,000	264,000	261,000	256,000
d. Interest on Project Debt	-	-	-	-	-	1,034,000	3,673,000	3,514,000	3,462,000	3,408,000
e. Current Depreciation	2,798,000	3,348,000	4,135,000	4,614,000	4,894,000	4,894,000	4,773,000	5,640,000	5,875,000	6,118,000
f. Project Depreciation	-	-	-	-	-	953,000	2,032,000	2,160,000	2,160,000	2,160,000
g. Current Amortization	15,000	15,000	-	-	-	147,000	147,000	147,000	147,000	147,000
h. Project Amortization										
i. Supplies	1,090,000	1,156,000	1,018,000	1,014,000	1,007,000	1,011,000	1,423,000	2,038,000	1,988,000	1,939,000
j. Other Expenses (Specify/add rows if needed)										
Dining Services	3,075,000	3,266,000	3,257,000	3,264,000	3,266,000	3,271,000	3,327,000	3,378,000	3,377,000	3,379,000
General and Administrative	4,621,000	5,270,000	5,272,000	5,272,000	5,292,000	5,522,000	5,849,000	6,048,000	6,065,000	6,083,000
Plant Operations	1,288,000	1,382,000	1,382,000	1,382,000	1,365,000	1,365,000	1,730,000	1,738,000	1,738,000	1,738,000
Housekeeping	881,000	883,000	882,000	698,000	699,000	706,000	927,000	985,000	990,000	994,000
Utilities	979,000	975,000	952,000	952,000	952,000	952,000	1,118,000	1,294,000	1,304,000	1,315,000
Loss on Disposal of Equipment	39,000	-	-	-	-	-	-	-	-	-
TOTAL OPERATING EXPENSES	***$ 22,817,000***	***$ 24,659,000***	***$ 25,391,000***	***$ 25,752,000***	***$ 25,984,000***	***$ 28,276,000***	***$ 34,081,000***	***$ 36,742,000***	***$ 36,903,000***	***$ 37,073,000***
3. NET INCOME										
a. Income From Operation	$ 2,497,000	$ 1,363,000	$ 768,000	$ 509,000	$ 444,000	$ 4,000	$ (513,165)	$ (1,167,628)	$ (1,100,828)	$ (1,001,496)
b. Non-Operating Income										
SUBTOTAL	***$ 2,497,000***	***$ 1,363,000***	***$ 768,000***	***$ 509,000***	***$ 444,000***	***$ 4,000***	***$ (513,165)***	***$ (1,167,628)***	***$ (1,100,828)***	***$ (1,001,496)***
c. Income Taxes										
NET INCOME (LOSS)	***$ 2,497,000***	***$ 1,363,000***	***$ 768,000***	***$ 509,000***	***$ 444,000***	***$ 4,000***	***$ (513,165)***	***$ (1,167,628)***	***$ (1,100,828)***	***$ (1,001,496)***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	36.5%	45.9%	30.0%	34.0%	34.0%	34.0%	33.0%	50.0%	51.0%	52.0%
2) Medicaid			0.0%	0.0%	0.0%	0.0%	13.0%	15.0%	15.0%	15.0%
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay	63.5%	54.1%	70.0%	66.0%	66.0%	66.0%	54.0%	35.0%	34.0%	33.0%
6) Other										
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days										
1) Medicare	16.5%	22.8%	12.0%	14.8%	14.8%	14.8%	14.2%	22.8%	22.8%	22.8%
2) Medicaid			0.0%	0.0%	0.0%	0.0%	12.3%	15.4%	15.4%	15.4%
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay	83.5%	77.2%	88.0%	85.2%	85.2%	85.2%	73.5%	61.8%	61.8%	61.8%
6) Other										
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***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 table.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY = FY	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
1. REVENUE							
a. Inpatient Services	$ 8,583,728	$ 8,637,600	$ 10,010,446	$ 11,006,313	$ 11,051,145	$ 11,119,663	$ 11,119,663
b. Outpatient Services							
Gross Patient Service Revenues	***$ 8,583,728***	***$ 8,637,600***	***$ 10,010,446***	***$ 11,006,313***	***$ 11,051,145***	***$ 11,119,663***	***$ 11,119,663***
c. Allowance For Bad Debt							
d. Contractual Allowance			$ 394,000	$ 532,000	$ 532,000	$ 532,000	$ 532,000
e. Charity Care							
Net Patient Services Revenue	***$ 8,583,728***	***$ 8,637,600***	***$ 9,616,446***	***$ 10,474,313***	***$ 10,519,145***	***$ 10,587,663***	***$ 10,587,663***
f. Other Operating Revenues (Specify)							
Amortization of entrance fees	$ 846,000	$ 1,047,000	$ 1,225,000	$ 1,251,000	$ 1,278,000	$ 1,306,000	$ 1,306,000
Investment income	$ 176,000	$ 213,000	$ 227,000	$ 217,000	$ 218,000	$ 220,000	$ 220,000
Other							
NET OPERATING REVENUE	***$ 9,605,728***	***$ 9,897,600***	***$ 11,068,446***	***$ 11,942,313***	***$ 12,015,145***	***$ 12,113,663***	***$ 12,113,663***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 5,795,000	$ 5,668,000	$ 5,268,000	$ 5,319,000	$ 5,319,000	$ 5,319,000	$ 5,319,000
b. Contractual Services							
c. Interest on Current Debt	10,000	13,000	47,000	45,000	44,000	43,000	43,000
d. Interest on Project Debt	-	208,000	738,000	706,000	695,000	684,000	673,000
e. Current Depreciation	847,000	847,000	805,000	951,000	991,000	1,032,000	1,072,000
f. Project Depreciation	-	191,000	408,000	434,000	434,000	434,000	434,000
g. Current Amortization							
h. Project Amortization							
i. Supplies	1,007,000	1,011,000	1,423,000	2,038,000	1,988,000	1,939,000	1,939,000
j. Other Expenses (Specify)							
Dining Services	565,000	566,000	561,000	570,000	570,000	570,000	570,000
General and Administrative	916,000	955,000	987,000	1,020,000	1,023,000	1,026,000	1,026,000
Plant Operations	236,000	236,000	292,000	293,000	293,000	293,000	293,000
Housekeeping	121,000	122,000	156,000	166,000	167,000	168,000	168,000
Utilities	165,000	165,000	189,000	218,000	220,000	222,000	222,000
TOTAL OPERATING EXPENSES	***$ 9,662,000***	***$ 9,982,000***	***$ 10,874,000***	***$ 11,760,000***	***$ 11,744,000***	***$ 11,730,000***	***$ 11,759,000***
3. INCOME							
a. Income From Operation	***$ (56,272)***	***$ (84,400)***	***$ 194,446***	***$ 182,313***	***$ 271,145***	***$ 383,663***	***$ 354,663***
b. Non-Operating Income							
SUBTOTAL	***$ (56,272)***	***$ (84,400)***	***$ 194,446***	***$ 182,313***	***$ 271,145***	***$ 383,663***	***$ 354,663***
c. Income Taxes							
NET INCOME (LOSS)	***$ (56,272)***	***$ (84,400)***	***$ 194,446***	***$ 182,313***	***$ 271,145***	***$ 383,663***	***$ 354,663***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare		84.0%	84.0%	84.0%	84.0%	84.0%	84.0%
2) Medicaid		16.0%	16.0%	16.0%	16.0%	16.0%	16.0%
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days							
1) Medicare		71.0%	71.0%	71.0%	71.0%	71.0%	71.0%
2) Medicaid		29.0%	29.0%	29.0%	29.0%	29.0%	29.0%
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Health Services Administrator	1.0	$124,000	$124,000			$0			$0	1.0	$124,000
Assistant Health Services Administrator	0.3	$97,000	$97,000			$0			$0	0.3	$97,000
Resident Assessment Coordinator	1.0	$89,000	$89,000			$0			$0	1.0	$89,000
Medical Records Supervisor	1.0	$65,000	$65,000			$0			$0	1.0	$65,000
Director of Nursing	1.0	$110,000	$110,000			$0			$0	1.0	$110,000
Supervisors	4.3	$86,000	$86,000	0.4	$86,000	$86,000			$0	4.7	$172,000
Lifestyle and Engagement	3.5	$84,000	$84,000	0.3	$84,000	$84,000			$0	3.8	$168,000
Total Administration	**12.1**		**$655,000**	**0.6**		**$170,000**			**$0**	**12.8**	**$825,000**
Direct Care Staff *(List general categories, add rows if needed)*											
RN Unit Manager	1.0	$76,000	$76,000			$0			$0	1.0	$76,000
RNs	11.0	$74,000	$74,000	0.6	$74,000	$74,000			$0	11.6	$148,000
LPNs	2.7	$59,000	$59,000	0.2	$59,000	$59,000			$0	2.9	$118,000
CNAs/Caregivers	30.9	$33,000	$33,000	2.7	$33,000	$33,000			$0	33.6	$66,000
Medication Aides	5.2	$38,000	$38,000	0.4	$38,000	$38,000			$0	5.6	$76,000
Total Direct Care	**50.7**		**$280,000**	**3.9**		**$204,000**	**0.0**		**$0**	**54.6**	**$484,000**
Support Staff *(List general categories, add rows if needed)*											
Lifestyle and Engagement	0.5	$42,000	$42,000			$0			$0	0.5	$42,000
Housekeeping	1.0	$23,000	$23,000	0.3	$23,000	$23,000			$0	1.3	$46,000
Clinical Admissions/Case Manager	1.0	$70,000	$70,000			$0			$0	1.0	$70,000
Unit Clerk	2.8	$39,000	$39,000			$0			$0	2.8	$39,000
Total Support	**5.3**		**$174,000**	**0.3**		**$23,000**	**0.0**		**$0**	**5.6**	**$197,000**
REGULAR EMPLOYEES TOTAL	***68.2***		**$1,109,000**	***4.8***		**$397,000**	***0.0***		**$0**	**73.0**	**$1,506,000**
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below):*											
As a percent of salaries and wages											
TOTAL COST	***68.2***		***$1,109,000***	***4.8***		***$397,000***	***0.0***		***$0***		***$1,506,000***

TABLE I. Scheduled Staff for Typical Work Week

INSTRUCTION: Quantify the staff that will provide bedside care that would be counted toward the current minimum staffing as required by COMAR 10.07.02.12

	Weekday Hours Per Day				Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**	**Day**	**Evening**	**Night**	**Total**
Registered Nurses	32.75	24.75	16.50	**74.00**	24.75	24.75	16.50	**66.00**
L. P. N. s	8.25	8.25	-	**16.50**	8.25	8.25	-	**16.50**
Aides	64.00	64.00	64.00	**192.00**	64.00	64.00	64.00	**192.00**
C. N. A.s	-	-	-	-	-	-	-	-
Medicine Aides	16.00	16.00	-	**32.00**	16.00	16.00	-	**32.00**
Total	**121.00**	**113.00**	**80.50**	**314.50**	**113.00**	**113.00**	**80.50**	**306.50**
Licensed Beds at Project Completion				**70**	**Licensed Beds at Project Completion**			**70**
Hours of Bedside Care per Licensed Bed per Day				**4.49**	**Hours of Bedside Care per Licensed Bed Per Day**			**4.38**

	Weekday Hours Per Day				Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**	**Day**	**Evening**	**Night**	**Total**
Ward Clerks (bedside care time calculated at 50%	4.00	4.00	-	8.00	4.00	4.00	-	8.00
Total Including 50% of Ward Clerks Time	**123.00**	**115.00**	**80.50**	**318.50**	**115.00**	**115.00**	**80.50**	**310.50**
Total Hours of Bedside Care per Licensed Bed Per Day				**4.55**	**Total Hours of Bedside Care per Licensed Bed Per Day**			**4.44**

70 SKILLED BEDS

Total Weekly Hours			
Day	Evening	Night	Total
213.25	173.25	115.50	**502.00**
57.75	57.75	-	**115.50**
448.00	448.00	448.00	**1,344.00**
-	-	-	**-**
112.00	112.00	-	**224.00**
831.00	**791.00**	**563.50**	**2,185.50**

FTEs			
Day	Evening	Night	Total
5.33	4.33	2.89	**12.55**
1.44	1.44	-	**2.89**
11.20	11.20	11.20	**33.60**
-	-	-	**-**
2.80	2.80	-	**5.60**
20.78	**19.78**	**14.09**	**54.64**

TABLE J. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☐
Class B	☐	☐
Class C	☑	☑
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☑
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		
Second Floor	5,127	25,513
Third Floor	5,539	1,577
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor	934	1,349
Third Floor	373	162
Fourth Floor		
Total Linear Feet	**1,307**	**1,511**
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor	11	11
Third Floor	13	13
Fourth Floor		
Average Wall Height	**12**	**12**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	0	2
Freight	0	1
Sprinklers	**Square Feet Covered**	
Wet System	10,666	27,090
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	Central plant w/ water source heat pumps	
Type of Exterior Walls for proposed project	Clad metal stud with continuous insulation.	

TABLE K. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHAL

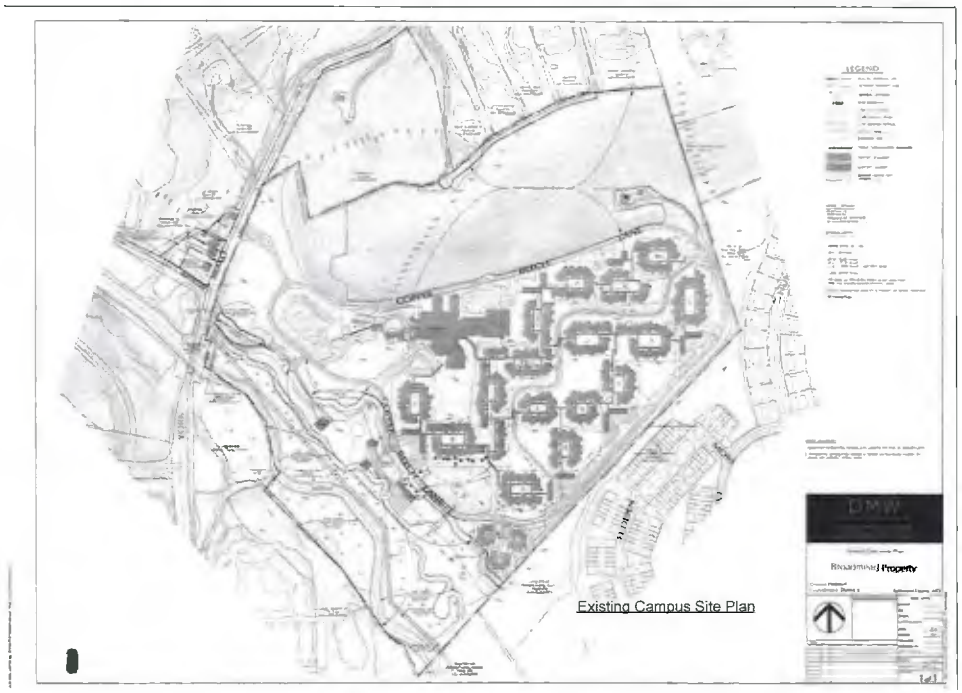
INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, r energy plants), complete an additional Table D for each structure.

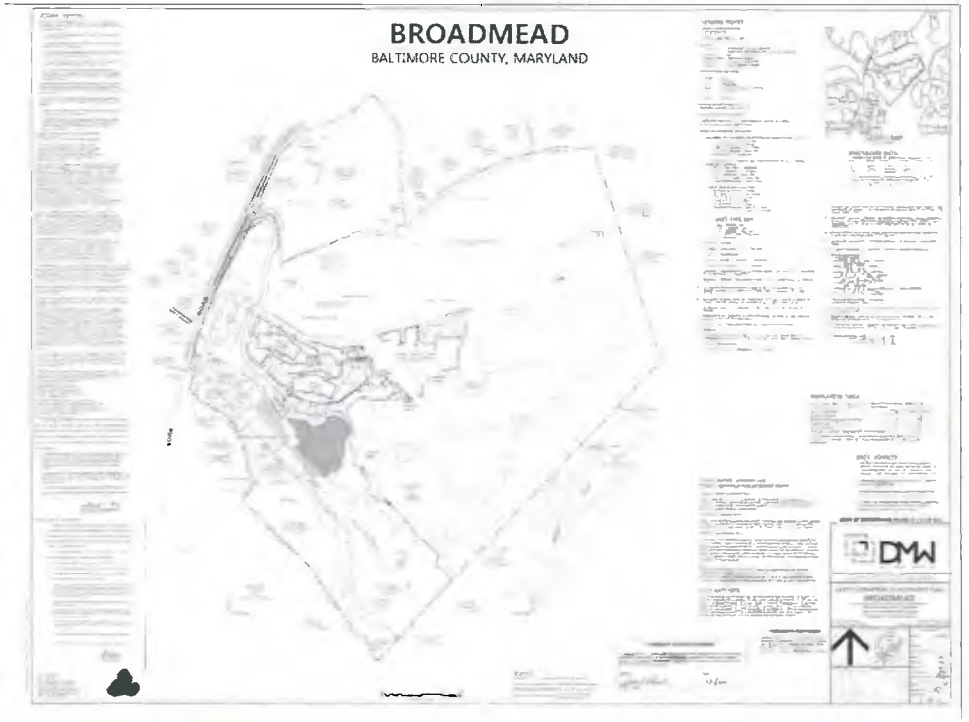
	NEW CONSTRUCTION COSTS
SITE PREPARATION COSTS	
Normal Site Preparation	$0
Utilities from Structure to Lot Line	$0
Subtotal included in Marshall Valuation Costs	
Site Demolition Costs	$35,000
Storm Drains	$75,000
Rough Grading	$65,000
Hillside Foundation	$0
Paving	$125,000
Exterior Signs	$0
Landscaping	$35,000
Walls	$0
Yard Lighting	$0
Other *(Specify/add rows if needed)*	$0
Sediment Control & Stabilization	$3,500
Helipad	$0
Water	$0
Sewer	$0
Premium for Minority Business Enterprise Requirement	$0
Outside the Loop	$0
Subtotal On-Site excluded from Marshall Valuation Costs	**$338,500**
OFFSITE COSTS	
Roads	$0
Utilities	$0
Jurisdictional Hook-up Fees	$0
Other *(Specify/add rows if needed)*	$0
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$338,500**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$338,500**

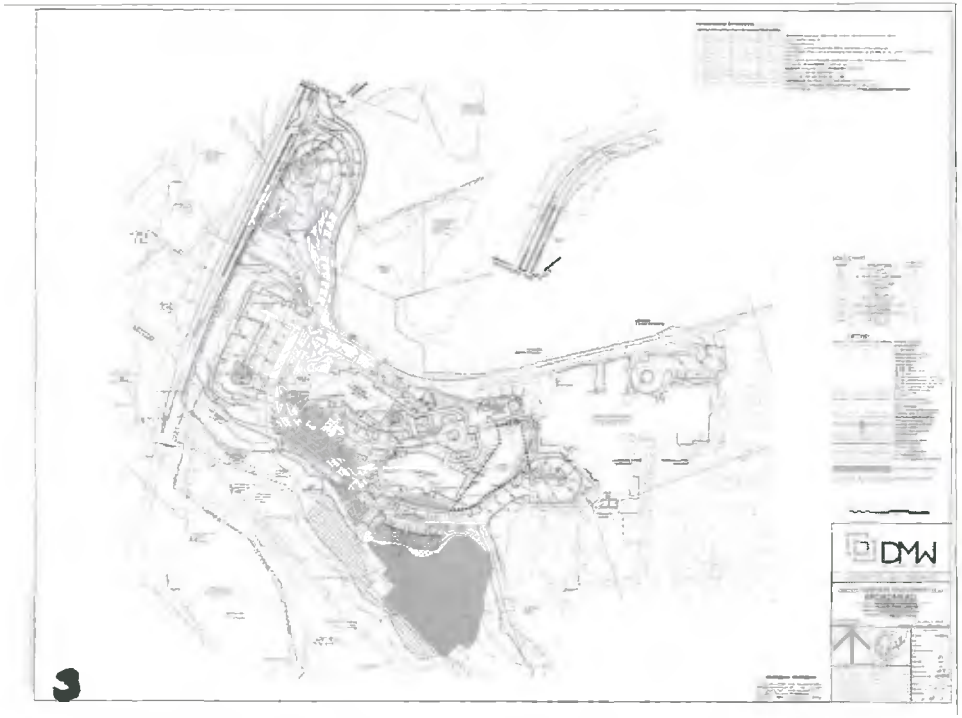
BUILDING COSTS	
Normal Building Costs	$2,236,150
Subtotal included in Marshall Valuation Costs	$2,236,150
Canopy	$0
Premium for Labor Shortages on Eastern Shore Projects	$0
LEED Silver Premium	$248,000
Siesmic Costs	$0
Pneumatic Tube System	$0
Transvac System	$0
Signs	$0
Premium for Minority Business Enterprise Requirement	$0
Subtotal Building Costs excluded from Marshall Valuation Costs	**$248,000**
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$2,484,150**
A&E COSTS	
Normal A&E Costs	
Subtotal included in Marshall Valuation Costs	**$0**
Amount Spent on the 2012 Project that is not now Usable:	
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$0**
PERMIT COSTS	
Normal Permit Costs	$5,000
Subtotal included in Marshall Valuation Costs	**$5,000**
Jurisdictional Hook-up Fees	$0
Impact Fees	$0
Amount Spent on the 2012 Project that is not now Usable	
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$0**
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	

TAB 3

PROJECT DRAWINGS


Existing Campus Site Plan
1


BROADMEAD
BALTIMORE COUNTY, MARYLAND
DMW
2


DMW
3

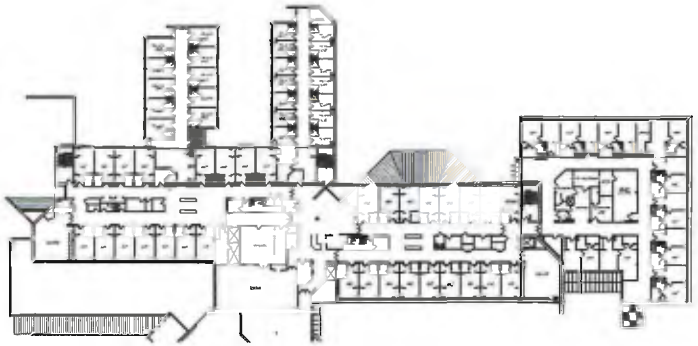

YORK RD
COPPER BEECH ROAD
Community Center
F.F. 298.50
GAR 285.00
4
Broadmead
Baltimore County, Maryland
Illustrative Site Plan
DMW

B- ASSISTED LIVING
BROADMEAD CENTER - EXISTING THIRD FLOOR PLAN

5

B- ASSISTED LIVING AND SKILLED CARE
BROADMEAD CENTER - PROPOSED THIRD FLOOR PLAN

6



C- SKILLED NURSING AND ASSISTED LIVING
BROADMEAD CENTER - EXISTING SECOND FLOOR PLAN

7

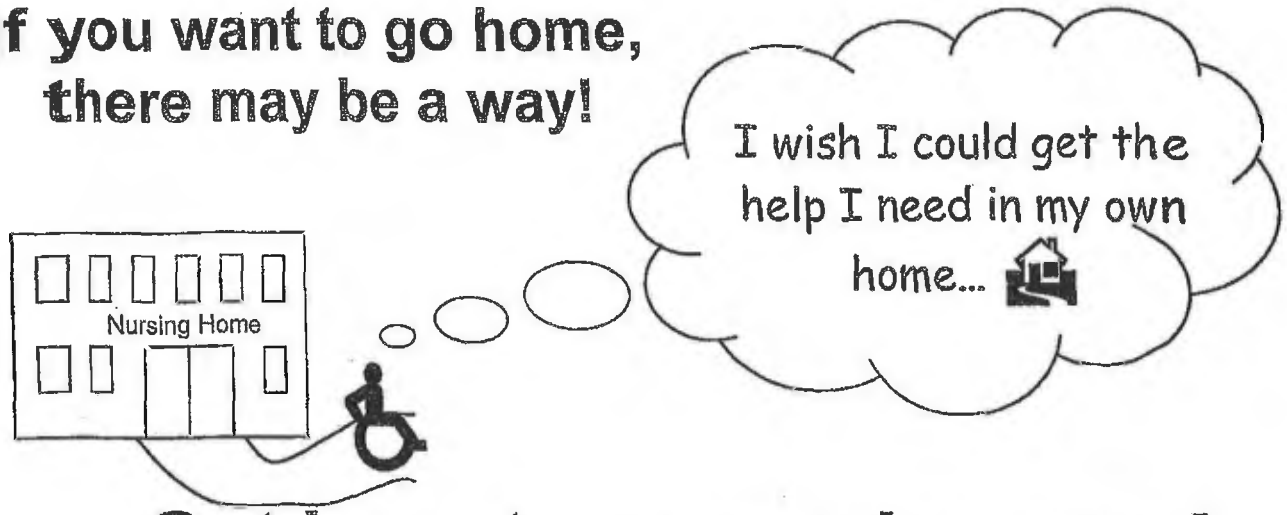
C- SKILLED NURSING, SKILLED NURSING DEMENTIA CARE, REHABILITATION, AND ASSISTED LIVING DEMENTIA CARE
BROADMEAD CENTER - PROPOSED SECOND FLOOR PLAN

8

TAB 4

MATERIALS FOR PROSPECTIVE RESIDENTS

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



Get long term services and supports in the community!

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

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

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

This document is produced by the Maryland Department of Health and Mental Hygiene. By law, nursing homes must give this information to every nursing home resident who indicates a preference to return to the community.
Revised 12/23/14

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

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

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

This document is produced by the Maryland Department of Health and Mental Hygiene. By law, nursing homes must give this information to every nursing home resident who indicates a preference to return to the community.
Revised 12/23/14

TAB 5

DISCHARGE PLANNING POLICY

Broadmead, Inc.

Policy Number	HC-04
Policy Title	Discharging Resident from Skilled Nursing Care
Effective Date	**Approved By:**
Revision Date	July 6, 2016 Robin Somers, COO
Regulation	
CARF Standard	
Related Entities	Broadmead, Inc.; Broadmead Medical Services, Inc.; Friends Care, Inc.; Friends Share, Inc.

Purpose:

The purpose of this procedure is to provide guidelines for the process of discharging a resident from skilled nursing care.

Policy:

Broadmead will support the resident and/or representative in the preparation of and transition from skilled nursing care.

Procedure:

1. Upon admission, the resident and, at resident's request, their representative, will participate in the discharge discussion and plan.
2. The discharge discussion begins upon admission and includes anticipated outcomes, goals, and realistic plans. The discharge plan may be revised as needed, based on therapy and clinical recommendations.
3. If the resident is discharging to another long-term care community, the resident will be provided with the following information:
    a. community name;
    b. address;
    c. contact name and telephone number.
4. If the resident is being discharged to home, the discharging nurse will ensure that the resident and/or responsible party receives teaching and discharge instructions to include:
    a. durable medical equipment needs;
    b. home safety evaluation outcomes, if applicable;
    c. other service needs upon discharge;
    d. a self-medication assessment, if applicable, and;
    e. a print out of the resident's current medication list.
5. If the resident is being discharged to a hospital or another community, the discharging nurse will ensure that a transfer summary is completed and delivered

to the receiving community, and that a telephone report is called to the receiving community.

6. The discharging nurse will assess and document resident's condition at discharge, including skin assessment, if medical condition allows.
7. All residents being discharged must be transported to the designated pick-up area by wheelchair.
8. The discharging nurse and/or designee will assemble any equipment or supplies necessary to discharge the resident.
9. The discharging nurse will verify that all personal items have been removed from the room occupied by the resident.

10. If the resident is being discharged to the mortuary:
    a. Ask family members or visitors to please wait outside of the resident's room while the nursing staff prepares the resident for release.
    b. Pull the cubicle curtain around the bed. Close the room entrance door.
    c. Perform post-mortem procedures.
    d. Wash and dry your hands thoroughly.
    e. Return the cubicle curtain to the open position only if it is a private room.
    f. Tell the family or visitors that they may enter the room. Keep the room door closed.
    g. As soon as the hearse arrives, ask visitors to step outside and close the room door.
    h. Nursing staff will assist placing the resident onto the stretcher if requested, and cover the resident with a sheet or blanket.
    i. Open the room entrance door. Escort the resident to the pick-up area.
    j. Assist in the loading procedures as necessary.
    k. Return to your assigned area.
    l. Wash and dry your hands thoroughly.
    m. Return to the resident's room.
    n. Knock before entering the resident's room, if applicable.
    o. Strip and clean the discharged resident's bed.
    p. Make the unoccupied bed.
    q. Discard soiled linen in the soiled linen hamper.
    r. Remove all unnecessary supplies and equipment. Store in designated area or return to supply area for cleaning and disinfection.
    s. Discard all disposable items into designated containers.
    t. Wash and dry your hands thoroughly.
    u. Lock door if a permanent resident, until family can make arrangements for packing and removing belongings.
11. The following information should be recorded in the resident's medical record:
    a. The date and time the discharge was made.
    b. The name and title of the individual(s) who assisted in the discharge.
    c. All assessment data obtained during the procedure, if applicable.
    d. How the resident tolerated the procedure, if applicable.
    e. If the resident refused the discharge, the reason(s) why and the intervention taken.

f. The signature and title of the person recording the data.

12. Notify the supervisor if the resident refuses the discharge.
13. Report other information in accordance with Broadmead policy and professional standards of practice.

Team Members:
Medical Director, Health Services Administrator, Assisted Living Director, Lifestyle Director, Social Work Director and Social Worker; OPD Director, Medical Records Manager.

TAB 6

QUALITY ASSURANCE POLICY

Broadmead, Inc.

Policy Number	ADM-08
Policy Title	Quality Assurance Performance Improvement Committee
Effective Date	July 6, 2016 **Approved By:** Robin Somers, COO
Revision Date	
Regulation	COMAR 10.07.02.45 and 10.07.02.46
CARF Standard	
Related Entities	Broadmead, Inc.; Broadmead Medical Services, Inc.; Friends Care, Inc.; Friends Share, Inc.

Purpose:

Broadmead shall establish and maintain a Quality Assurance Performance Improvement (QAPI) Committee that oversees the identification, evaluation, root cause, and management of quality issues and improvements.

Policy:

It is the policy of Broadmead to maintain a quality assurance and performance improvement process to ensure quality of care in the licensed care areas of the Broadmead community.

The primary goals of the Quality Assurance Performance Improvement Committee are:

1. To monitor and evaluate the appropriateness and quality of care provided within the framework of the Quality Assurance Performance Improvement Plan to include: Concurrent Review, Ongoing Monitoring, Patient Complaints, Accident and Incidents, Abuse and Neglect.
2. To oversee community systems and processes related to improving quality of care and services;
3. To promote consistent community systems and processes and appropriate practices in resident wellness;
4. To implement plans to correct identified issues in quality of care;
5. To establish effective accountability for care quality; and
6. To coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between community staff, residents, and family members.
7. To explore best practice within the field of aging.

Procedure:

The Quality Assurance Performance Improvement Coordinator shall coordinate the activities of the Committee.

1. The following individuals will serve on the committee:
    a. Committee Chairperson – Health Services Administrator (mandatory);
    b. Director of Nursing Services (mandatory);
    c. Medical Director (mandatory);
    d. GNA (Mandatory);
    e. Dietitian (mandatory);
    f. Pharmacy Representative (quarterly attendance);
    g. Social Worker (mandatory);
    h. Activities Representative (quarterly attendance);
    i. Environmental Services Representative (quarterly attendance);
    j. Rehabilitative/Restorative Services Representative (quarterly attendance);
    k. Safety Representative; (quarterly attendance);and
    l. Medical Records Representative (quarterly attendance).
    m. The Quality Assurance Coordinator (mandatory)
    n. All other departments will attend quarterly

The committee will meet monthly at a regularly scheduled time. Special meetings may be called by the Committee Chairperson, as needed, to address issues that cannot be held until the next regularly scheduled meeting.

The Committee Chairperson shall maintain minutes of all regular and special meetings that include at least the following information:

a. The date and time the committee met;
b. The names, titles and signatures of committee members present;
c. A summary of the reports and findings;
d. A summary of any approaches and action plans to be implemented to include responsible department or person and when the plans will be implemented and reviewed by the committee;
e. Conclusions and recommendations from the committee; and
f. Copies of minutes shared with the Family Council, Ombudsman and Resident Council.
g. Committee minutes shall reflect monthly input from the Medical Director regarding physician issues and general community clinical care issues.

The Quality Assurance Performance Improvement Chairperson shall ensure that meeting minutes are distributed to all committee members and others prior to the meeting, or as needed.

The committee will oversee the development and implementation of actions to correct quality concerns, trends, review major community projects, incorporate regulation changes and, promote overall quality of care and services in the community.

All Quality Assurance Performance Improvement minutes, reports, findings, plans of corrections, etc., are confidential and shall be filed separately from other committee documentation to maintain such confidentiality. Committee members shall keep confidential all information that they obtain as a result of their participation in/on the committee. The Health Services Administrator may authorize sharing of summaries or periodic evaluations of the Quality Assurance Performance Improvement Program with residents and/or other interested persons or organizations. These should not include confidential information.

The Quality Assessment and Assurance Committee will review all department reports and summarize the findings in the committee minutes. The Quality Assurance Performance Improvement Committee shall help various departments, committees, disciplines, and individuals develop and implement plans of correction and monitoring approaches. These plans and approaches should include specific time frames for implementation and follow-up. The committee shall track the progress of any active plans of correction through completion. The committee shall advise the administration of the need for policy or procedural changes and, as appropriate, monitor to ensure that such changes are implemented.

The Quality Assurance Performance Improvement Committee shall review the QAPI Plan at least annually for necessary revisions, and shall document any such changes.

1. Concurrent review for each resident will include criteria to determine a change in a resident's condition, a method to document the concurrent review and identification of the licensed nurse or nurses conducting the concurrent review.
2. Clinical data to review a change in condition will include: medication, laboratory values, intake and output, skin breakdown, noted weights, appetite, injuries resulting from accidents or incidents and any other relevant parameters that may affect the resident's status.
3. Ongoing monitoring will include a description of measureable criteria with all aspects of resident care to include: medication administration, prevention of decubitus ulcers, dehydration, and malnutrition, nutritional status and weight loss or weight gain, accidents or injuries, unexpected death and changes in physical or mental status.
4. Patient complaints will be logged to include the name of the complainant, date the complaint was received, nature of the complaint and date the complainant was notified of the resolution of the complaint.
5. Accident and injuries will be evaluated to determine trends and patterns.
6. Abuse and neglect information will be shared with the committee to include resolution and outcomes.
7. Concurrent review, ongoing monitoring, patient complaints, accidents and incidents, abuse and neglect data will be shared monthly.

Team Members:

Health Services Administrator, Director of Nursing

TAB 7

AUDITED FINANCIAL STATEMENT

BROADMEAD, INC. AND AFFILIATE

COMBINED FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2016 AND 2015

BROADMEAD, INC. AND AFFILIATE
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YEARS ENDED JUNE 30, 2016 AND 2015

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INDEPENDENT AUDITORS' REPORT

Board of Directors
Broadmead, Inc. and Affiliate
Cockeysville, Maryland

Report on the Financial Statements
We have audited the accompanying combined financial statements of Broadmead, Inc. and Affiliate, which comprise the combined statements of financial position as of June 30, 2016 and 2015 and the related combined statements of activities and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Managements Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility
Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of Broadmead, Inc. and Affiliate as of June 30, 2016 and 2015, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Plymouth Meeting, Pennsylvania
September 19, 2016

BROADMEAD, INC. AND AFFILIATE
COMBINED STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2016 AND 2015

	2016	2015
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 4,276,255	$ 3,414,284
Accounts Receivable	881,809	883,743
Entrance Fee Accounts Receivable	2,924,168	4,379,604
Due from Related Party	111,242	131,002
Inventory	118,758	107,676
Prepaid Expenses	384,396	367,530
Total Current Assets	8,696,628	9,283,839
ASSETS WHOSE USE IS LIMITED, NET		
By Board Designation:		
Reserve Funds	20,638,928	20,574,975
Broadmead General Fund	12,711,983	13,347,496
Other	540,643	557,254
Total Assets Whose Use is Limited, Net	33,891,554	34,479,725
INVESTMENTS	15,541,945	15,139,230
PROPERTY AND EQUIPMENT, NET	35,162,580	32,000,802
Total Assets	$ 93,292,707	$ 90,903,596

See accompanying Notes to Combined Financial Statements.

LIABILITIES AND NET ASSETS	2016	2015
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	$ 2,760,646	$ 1,940,135
Current Portion of Annuities Payable	23,990	25,000
Bond Interest Payable	9,130	7,137
Compensated Absences	645,495	620,739
Current Portion of Long-Term Debt	945,224	909,158
Total Current Liabilities	4,384,485	3,502,169
LONG-TERM DEBT	6,559,157	7,490,050
LINE OF CREDIT	824,757	824,757
ANNUITIES PAYABLE	101,609	113,828
DEPOSITS FROM PROSPECTIVE RESIDENTS	287,500	180,000
REFUNDABLE ENTRANCE FEES	17,112,526	15,782,089
DEFERRED REVENUE FROM ENTRANCE FEES	23,131,101	21,971,583
Total Liabilities	52,401,135	49,864,476
NET ASSETS		
Unrestricted:		
Operations	11,877,746	11,661,590
Donor Unrestricted	13,382,377	13,446,996
Board Designated - Other	540,643	557,254
Total Unrestricted	25,800,766	25,665,840
Temporarily Restricted	11,258,404	11,540,878
Permanently Restricted	3,832,402	3,832,402
Total Net Assets	40,891,572	41,039,120
Total Liabilities and Net Assets	$ 93,292,707	$ 90,903,596

BROADMEAD, INC. AND AFFILIATE
COMBINED STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2016 AND 2015

	2016	2015
REVENUE		
Resident Care Services	$ 17,137,941	$ 15,814,400
Medical Revenue	2,020,387	1,826,809
Amortization of Entrance Fees	4,741,543	4,661,127
Interest and Dividends, Net of Fees	729,313	772,555
Realized Gains	237,695	799,545
Contributions	48,458	117,748
Other	788,512	906,021
Net Assets Released from Restrictions	317,696	415,791
Total Revenue	26,021,545	25,313,996
EXPENSES		
Health Services	7,554,241	7,239,113
Dining Services	3,829,928	3,622,056
General and Administrative	5,858,024	5,191,533
Depreciation	3,363,141	2,798,091
Plant Operations	1,959,871	1,751,618
Housekeeping	980,369	1,072,227
Utilities	975,432	978,841
Interest	139,541	124,118
(Gain) Loss on Disposal of Property and Equipment	(133)	39,224
Total Expenses	24,660,414	22,816,821
EXCESS OF REVENUE OVER EXPENSES	1,361,131	2,497,175
OTHER CHANGES		
Unrealized Losses	(1,226,205)	(1,039,211)
Total Other Changes	(1,226,205)	(1,039,211)
Increase in Unrestricted Net Assets	134,926	1,457,964
CHANGES IN TEMPORARILY RESTRICTED NET ASSETS		
Interest and Dividends, Net of Fees	354,029	383,793
Realized Gains	120,128	406,997
Contributions	143,735	159,489
Unrealized Losses	(582,670)	(517,132)
Net Assets Released from Restrictions	(317,696)	(415,791)
(Decrease) Increase in Temporarily Restricted Net Assets	(282,474)	17,356
(Decrease) Increase in Net Assets	(147,548)	1,475,320
Net Assets - Beginning of Year	41,039,120	39,563,800
NET ASSETS - END OF YEAR	$ 40,891,572	$ 41,039,120

See accompanying Notes to Combined Financial Statements.

BROADMEAD, INC. AND AFFILIATE
COMBINED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2016 AND 2015

	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
(Decrease) Increase in Net Assets	$ (147,548)	$ 1,475,320
Adjustments to Reconcile Increase in Net Assets to		
Net Cash Provided by Operating Activities:		
Unrealized Losses	1,808,875	1,556,343
Realized Gains	(357,823)	(1,206,542)
Depreciation	3,363,141	2,798,091
(Gain) Loss on Disposal of Property and Equipment	(133)	39,224
Amortization of Entrance Fees	(4,741,543)	(4,661,127)
Proceeds from Entrance Fees	8,726,934	7,748,161
(Increase) Decrease in Assets:		
Accounts Receivable	1,934	(388,626)
Prepaid Expenses and Inventory	(27,948)	(151,176)
Due from Related Party	19,760	72,404
Increase (Decrease) in Liabilities:		
Accounts Payable and Accrued Expenses	820,511	531,399
Annuities Payable	(13,229)	(27,848)
Bond Interest Payable	1,993	(2,257)
Compensated Absences	24,756	(25,447)
Deposits from Prospective Residents	107,500	31,500
Net Cash Provided by Operating Activities	9,587,180	7,789,419
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of Property and Equipment	(6,524,786)	(6,393,743)
Purchase of Assets Whose Use is Limited and Investments, Net	(1,265,596)	(1,179,992)
Net Cash Used by Investing Activities	(7,790,382)	(7,573,735)
CASH FLOWS FROM FINANCING ACTIVITIES		
Line of Credit Draws	-	824,757
Repayment of Long-Term Debt	(894,827)	(886,596)
Refunds of Entrance Fees	(40,000)	(96,608)
Net Cash Used by Financing Activities	(934,827)	(158,447)
NET INCREASE IN CASH AND CASH EQUIVALENTS	861,971	57,237
Cash and Cash Equivalents - Beginning of Year	3,414,284	3,357,047
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 4,276,255	$ 3,414,284
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Amount Included in Accounts Payable for Construction in Progress	$ 614,419	$ 125,591
Cash Paid During the Year for Interest	112,339	109,759

See accompanying Notes to Combined Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Broadmead, Inc. is a life plan (formerly continuing care retirement) community, accredited by the Continuing Care Accreditation Commission (CARF-CCAC), near Baltimore, Maryland. It offers independent living, enriched living, assisted living, and comprehensive care on a 94 acre campus nestled in the rolling hills of Hunt Valley, Maryland.

Broadmead Medical Services, Inc., an affiliate of Broadmead, Inc., is a not-for-profit corporation which provides certain physician and related services to residents of Broadmead, Inc.

Broadmead, Inc. and Broadmead Medical Services, Inc. (the Corporation) are supported by Friends Care, Inc. (a not-for-profit organization) whose mission is to support the development and management of a wide range of programs, services, and facilities which enhance the quality of life for a diverse population of older persons.

Financial Statement Presentation and Combination

The combined financial statements include the accounts of Broadmead, Inc. and its affiliate, Broadmead Medical Services, Inc. All significant intercompany accounts and transactions have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

The Corporation considers all highly liquid investments with a maturity of three months or less when purchased to be cash and cash equivalents, excluding those classified as investments or assets whose use is limited.

The Corporation typically maintains cash and cash equivalents in local banks. Cash is insured by the Federal Deposit Insurance Corporation up to a limit of $250,000 per bank. At times during the years ended June 30, 2016 and 2015, cash balances may have exceeded the federally insured limit. Fixed income securities, equity securities, equity mutual funds, and alternative investments are uninsured.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Accounts Receivable

The Corporation provides an allowance for uncollectible accounts based on the allowance method using management's judgment considering historical information. Residents are not required to provide collateral for services rendered. Accounts receivable under cost reimbursement plans, net of contractual allowances, are subject to audit and retroactive adjustment by third-party payors. Unpaid balances remaining after the stated payment terms are considered past due. Recoveries of previously charged off accounts are recorded when received. When all collection efforts have been exhausted, the accounts are written off against the related allowance. At June 30, 2016 and 2015, the allowance for uncollectible accounts was $18,882 and $22,920, respectively.

Entrance Fee Accounts Receivable

Entrance fee accounts receivable represent entrance fees that are deferred for up to one year after a resident occupies a unit. The receivables are expected to be collected during the immediate subsequent fiscal year and are included in current assets as of June 30, 2016. Management determined that no allowance is necessary on entrance fee accounts receivable.

Inventory

Inventory is stated at the lower of cost (determined on a first-in, first-out basis) or market and consists of food, linen, and maintenance inventories.

Assets Limited as to Use and Investments

Assets limited as to use consist of investments designated by the board for specific purposes. Investments and assets limited as to use are measured at fair value, with the exception of the investments in the captive insurance program and land, which are valued at cost. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in excess of revenue over expenses unless the income or loss is restricted by donor or by law. Unrealized gains and losses on investments are excluded from excess of revenues over expenses.

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value as determined by a national exchange with the exception of alternative investments. Alternative investments are valued at net asset value per share.

Investments are comprised of a variety of financial instruments held by investment advisors. The fair values reported in the combined statements of financial position are subject to various risk, including changes in the equity markets, the interest rate environment, and general economic conditions. Due to the level of risk associated with certain investment securities, it is reasonably possible that the amounts reported in the accompanying combined financial statements could change materially in the near term.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Fair Values of Financial Instruments

Accounting principles generally accepted in the United States of America establish a fair value hierarchy that prioritizes the inputs to valuation methods used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

Level 1: Unadjusted quoted prices in active markets that are accessible at the measurement date for identical assets or liabilities.

Level 2: Quoted prices in markets that are not active, or inputs that are observable either directly or indirectly, for substantially the full term of the asset or liability.

Level 3: Prices or valuation techniques that require inputs that are both significant to the fair value measurement and unobservable (i.e. supported with little or no market activity).

Property and Equipment

Property and equipment are stated at cost. The Corporation's policy is to capitalize all property and equipment purchased in excess of $500. Depreciation is computed on the straight-line method over the estimated useful lives of the assets. Estimated useful lives are as follows: building and improvements, ten to forty years, and furniture and equipment, five to twenty years. Donated property is recorded at estimated fair value at the date of receipt. Maintenance and repairs are charged to expense as incurred; major renewals and betterments are capitalized. When items of property and equipment are sold or retired, the related cost and accumulated depreciation are removed from the accounts and any gain or loss is included in the combined statement of activities and changes in net assets.

The Corporation evaluates its property and equipment for impairment as events or changes in circumstances indicate that the carrying amount of such assets may not be fully recoverable. In such circumstances, the Corporation evaluates the recoverability of property and equipment by measuring the carrying amount of the assets against the estimated future undiscounted cash flows associated with such assets. At the time such evaluations indicate the future undiscounted cash flows of certain property and equipment are not sufficient to recover the carrying value of such assets, the assets are adjusted to their fair values. As of June 30, 2016 and 2015, management believes the carrying amount of the property and equipment has not been impaired.

Deferred Financing Costs

Deferred financing costs represent expenses incurred in issuing bonds (underwriting, legal, consulting, and other costs) through the Maryland Health and Higher Educational Facilities Authority. These costs are being amortized over the average life of the bonds using the straight-line method which approximates the effective interest method. In conjunction with the adoption of ASU 2015-03, deferred financing costs are presented as a reduction of the related borrowings.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Net Assets

Net assets are classified as unrestricted, temporarily restricted or permanently restricted. Unrestricted net assets have no donor-imposed restrictions. Unrestricted net assets may be further classified as assets limited as to use depending upon whether the Board of Trustees has designated these assets for specific purposes. Temporarily restricted net assets have donor-imposed restrictions that will expire upon satisfaction of the donor restrictions. Permanently restricted net assets are subject to donor-imposed stipulations to be maintained in perpetuity.

Obligation to Provide Future Service

The Corporation periodically calculates the present value of the net cost of future service and use of facilities to be provided to current residents and compares that amount with the balance of deferred revenue from advance fees. If the present value of the net cost of future services and use of facilities exceeds the deferred revenue from advance fees, a liability is recorded (obligation to provide future services and use of facilities) with the corresponding charge to operations. The obligation is discounted at 6%. No obligation existed as of June 30, 2016 and 2015.

Deposits from Prospective Residents

Priority deposits are received from prospective residents entitling them to priority for the assignment of available units. Priority deposits are applied against the total entrance fee upon occupancy or are refunded to the prospective residents who withdraw from the priority deposit list.

Resident Care Services and Medical Revenue

Resident care services revenue includes monthly charges related to services provided to residents. The monthly charges paid by the residents in accordance with the Residence and Care Agreement are recognized as earned in the month following the month billed.

Medical revenue under third-party payor agreements is subject to audit and retroactive adjustment. Third-party payor settlements are recognized in the year the retroactive settlement is received. Differences between the estimated amounts accrued and interim and final settlements are reported in the combined statement of activities and changes in net assets in the year of settlement.

Donor Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation which are restricted by the donor for specific purposes are reported at fair value at the date the promise is received. Conditional promises to give are recognized only when the conditions on which they depend are substantially met and the promises become unconditional. The gifts are reported as either temporarily or permanently restricted based on the nature of the donor's restriction. When a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the combined statements of activities and changes in net assets as net assets released from restrictions. Permanently restricted contributions generally require that the original contribution be maintained permanently but allows the use of all or part of the related income.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Donated Services

A significant number of volunteers annually donate their services to the Corporation. The value of these services is not reflected in the combined financial statements.

Lease Agreements

Annual rentals pertaining to leases which merely convey the right to use property are charged to current operations. Lease agreements which are substantially installment purchases of property are recorded as assets and depreciated over their estimated useful lives.

Excess of Revenue Over Expenses

The combined statements of activities and changes in net assets include excess of revenue over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from such amount, consistent with industry practice, include unrealized gains and losses.

Income Taxes

Broadmead, Inc. and its affiliate are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code and are exempt from federal income taxes on related income pursuant to Section 509(a) of the Code.

The Corporation follows the provisions of the income tax standard regarding the recognition and measurement of uncertain tax positions. Management has determined that this standard does not have a material impact on the combined financial statements.

The Corporation is not aware of any activities that would jeopardize its tax-exempt status.

Change in Accounting Policies

The Corporation has adopted the accounting guidance in FASB Accounting Standards Update (ASU) No. 2015-03, *Interest—Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*. ASU 2015-03 requires organizations to present debt issuance costs as a direct deduction from the face amount of the related borrowings, amortize debt issuance costs using the effective interest method over the life of the debt, and record the amortization as a component of interest expense. The effect of adopting the new standard decreased the debt issuance costs asset to zero and decreased the debt liability by $118,157 as of June 30, 2015. The adoption of the standard had no effect on previously reported net assets. The ASU is effective for fiscal years beginning after December 15, 2015, with early adoption permitted. The ASU is retrospectively applied. The Corporation has elected to adopt this change in accounting principle as of July 1, 2015, prior to its effective date.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Change in Accounting Policies (Continued)

During the year ended June 30, 2016, the Corporation early adopted a provision of Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) 2016-01, *Financial Instruments – Overall: Recognition and Measurement of Financial Assets and Financial Liabilities*. This provision eliminates the requirement for entities, other than public business entities, to disclose the fair values of financial instruments carried at amortized cost, as previously required by Accounting Standards Codification (ASC) 825-10-50. As such, the Corporation has omitted this disclosure for the years ended June 30, 2016 and 2015. The early adoption of this provision did not have an impact on the Corporation's financial position or results of operations.

Revenue from Contracts with Customers

In May 2014, the Financial Accounting Standards Board (FASB) issued amended guidance to clarify the principles for recognizing revenue from contracts with customers. The guidance requires an entity to recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which an entity expects to be entitled in exchange for those goods or services. The guidance also requires expanded disclosures relating to the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. Additionally, qualitative and quantitative disclosures are required regarding customer contracts, significant judgments and changes in judgments, and assets recognized from the costs to obtain or fulfill a contract. The guidance will initially be applied retrospectively using one of two methods. The standard will be effective for the Corporation for annual reporting periods beginning after December 15, 2018. Management is evaluating the impact of the amended revenue recognition guidance on the Corporation's financial statements.

Reclassifications

Certain items in the prior year financial statements have been reclassified to conform to the current year's presentation. These reclassifications had no effect on the increase in net assets or on the overall net assets of the Corporation.

Subsequent Events

In preparing these financial statements, the Corporation has evaluated subsequent events and transactions for potential recognition and disclosure through September 19, 2016, the date the combined financial statements were issued.

NOTE 2 ASSETS LIMITED AS TO USE AND INVESTMENTS

Investments and assets whose use is limited consist of the following as of June 30:

	2016	2015
Cash and Cash Equivalents	$ 5,216,480	$ 5,031,398
Fixed Income Securities	8,566,876	9,920,233
Equity Securities	16,199,415	15,867,606
Mutual Funds	16,837,223	16,867,217
Alternative Investments	2,425,925	1,744,921
Total	49,245,919	49,431,375
Captive Insurance Program	187,580	187,580
Investments and Assets Whose Use is Limited	$ 49,433,499	$ 49,618,955

Investment income consists of the following for the years ended June 30:

	2016	2015
Interest and Dividends	$ 1,083,342	$ 1,301,416
Realized Gains	357,823	1,206,542
Unrealized Gains (Losses)	(1,808,875)	(1,556,343)
Less: Fees	(72,907)	(145,068)
Total Investment (Loss) Income	$ (440,617)	$ 806,547

NOTE 3 REQUIRED OPERATING RESERVES

The Maryland Department of Aging requires that Continuing Care Retirement Communities maintain an operating reserve equal to 15% of the previous fiscal year's net operating expenses as defined by the law. Expenses for Broadmead Medical Services, Inc. have been removed from total operating expenses as they do not apply to this calculation. As of June 30, 2016 and 2015, the Corporation has fully funded this requirement. The required operating reserve is included in the cash and marketable securities of the Reserve Funds which have fair market values of $20,638,928 and $20,574,975 as of June 30, 2016 and 2015, respectively.

NOTE 3 REQUIRED OPERATING RESERVES (CONTINUED)

Operating reserve requirement is calculated as follows based on the previous fiscal years operating expenses for the year ended:

	June 30, 2016	June 30, 2015
Operating Expenses	$ 22,816,821	$ 21,944,305
Less:		
Depreciation	2,798,091	2,690,245
Interest	124,118	119,117
Loss on Disposal of Property and Equipment	39,224	304,811
Net Operating Expenses	$ 19,855,388	$ 18,830,132
Operating Reserve (15% of Net Operating Expenses)	$ 2,978,308	$ 2,824,520

NOTE 4 PROPERTY AND EQUIPMENT

Property and equipment consist of the following for the years ended June 30:

	2016	2015
Land	$ 1,590,974	$ 1,590,974
Building and Improvements	57,071,778	54,621,505
Furniture and Equipment	13,891,480	13,215,202
Construction in Progress	2,803,101	546,477
Total	75,357,333	69,974,158
Accumulated Depreciation	(40,194,753)	(37,973,356)
Total Property and Equipment, Net	$ 35,162,580	$ 32,000,802

Depreciation expense for the years ended June 30, 2016 and 2015 totaled $3,363,141 and $2,798,091, respectively.

NOTE 5 LINE OF CREDIT AND LONG-TERM DEBT

The Corporation maintains an unsecured line of credit of $500,000 for its working capital needs. For the years ended June 30, 2016 and 2015, the interest rate on amounts drawn was the prime rate. This arrangement is renewed annually. As of June 30, 2016 and 2015, no amounts were outstanding under this agreement.

NOTE 5 LINE OF CREDIT AND LONG-TERM DEBT (CONTINUED)

On January 24, 2014, the Corporation entered into a $6,100,000 line of credit with the financial institution with the interest rate at the daily LIBOR rate plus 0.65%. The line of credit is set to expire January 24, 2019. Collateral for the line of credit includes various investments held by the Corporation. As of June 30, 2016 and 2015, $824,757 and $824,757 were outstanding respectively under this agreement.

On July 1, 2010, the Corporation entered into a financing agreement with PNC Bank (Bank), through the Maryland Health and Higher Educational Facilities Authority (MHHEFA), to finance the construction, renovation and equipping of the Corporations' facilities in an amount up to $12,000,000. The bond proceeds were used to refinance the Series 1997 revenue bonds. The bond shall bear interest at the Index Floating Rate, which was 1.44% at June 30, 2016 (capped at 4.3625%), and shall be calculated on the basis of a 360 day year for the actual number of days elapsed and shall be payable on the first business day of each month. Upon the request of the Corporation, MHHEFA may elect to convert the bond to a fixed rate on any date on which the bond is subject to redemption upon no less than five days' notice to the bank and the trustee. The Corporation granted a lien and claim on and a security interest in all of the entrance fees, monthly fees, receipts, revenues rentals, income, insurance proceeds and other moneys received by or on behalf of the Corporation.

As of June 30, 2016 and 2015, management believes that the Corporation is in compliance with the covenants required by the above financing agreement.

Long-term debt consists of the following as of June 30:

	2016	2015
2010 Bonds Outstanding	$ 7,608,207	$ 8,517,365
Less: Unamortized Debt Issuance Costs	(103,826)	(118,157)
Total Long-Term Debt, Net	7,504,381	8,399,208
Less: Current Portion	(945,224)	(909,158)
Total Long-Term Debt, Less Current Maturities	$ 6,559,157	$ 7,490,050

As of June 30, 2016, principal maturities over the next five years and thereafter are as follows:

Year Ending June 30,	Amount
2017	$ 945,224
2018	974,390
2019	240,334
2020	247,832
2021	255,564
Thereafter	4,944,863
Total	$ 7,608,207

NOTE 6 GIFT ANNUITIES

The Corporation is the beneficiary and trustee of certain charitable gift annuities with assets totaling $270,968 and $303,026 reserved in separate investment accounts as of June 30, 2016 and 2015, respectively. The present value of the future payments of the initial gifts was recorded based on the Corporation's obligation to make periodic payments of agreed amounts over the annuitants' lives and were discounted at rates varying from 1.2% and 4.6% based on the Charitable Mid-term Federal Rate issued by the IRS for split-interest agreements. As of June 30, 2016 and 2015, the Corporation recorded a liability to the annuitants of $125,599 and $138,828, respectively.

NOTE 7 TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

The following summarizes temporarily and permanently restricted net assets as of June 30:

	2016	2015
Temporarily Restricted:		
Broadmead Residents' Assistance Fund	$ 8,391,377	$ 8,474,299
Taylor Fund	232,399	219,781
Hallowell Fund	303,533	305,623
Homewood Friends Meeting Fund	81,713	82,171
Nursing Assistance Fund	214,921	216,368
Gabriele Bruck Special Needs Fund	1,327,104	1,485,582
Holly House Fund	8,699	8,580
Staff Assistance Fund	110,929	111,968
Private Companion Fund	3,791	3,741
John A. Boynton Scholarship Assistance Fund	101,782	126,565
Donnie Bay Nursing Education Scholarship Fund	-	(2,223)
Ann Michener Memorial Diversity Lecture Fund	4,803	4,829
Walking Trail Fund	278,042	284,456
Guyton Fund for Trees and Plants	27,076	28,453
Compton Fund	26,865	26,487
Gift Annuities	145,370	164,198
Total	$ 11,258,404	$ 11,540,878
Permanently Restricted:		
Gabriele Bruck Special Needs Fund	$ 3,728,363	$ 3,728,363
Guyton Fund for Trees and Plants	104,039	104,039
Total	$ 3,832,402	$ 3,832,402
Net Assets Released from Restrictions:		
Gabriele Bruck Special Needs Expenses	$ 116,495	$ 90,684
John A. Boyton Scholarship Assistance	36,436	55,136
Resident Subsidies	136,200	159,540
Donnie Bay Nursing Education Scholarship	-	13,044
Walking Trails Fund	5,502	7,865
Other	998	3,293
Gift Annuities	22,065	86,229
Total	$ 317,696	$ 415,791

NOTE 8 REVENUE RECOGNITION

Entrance Fees

Resident entrance fees are paid in full upon occupancy and represent the Corporation's obligation to provide continuing care to the residents. Non-refundable entrance fees are contractually refundable over a period that expires over 48 months: 6% in the first month of occupancy and 2% per month thereafter. The contractual refundable amount to all current residents based on the provisions of their Residence and Care Agreements is $17,112,526 and $15,782,089 as of June 30, 2016 and 2015, respectively.

Resident entrance fees are deferred upon occupancy and recognized as income over the remaining life expectancy of each resident or joint residents' expected remaining lives from their date of occupancy. Upon termination of a contract through death or withdrawal after occupancy, any unamortized entrance fee is recorded as income.

The Corporation offers an Incremental Entrance Fee Payment Amendment to the Residence and Care Agreement to residents who have entered into a Residence and Care Agreement, but do not have sufficient cash currently available to pay the entrance fee in full as required. The Corporation agrees to waive timely payment of the full entrance fee for a period of one year provided that, in addition to the full payment of the monthly fee, the resident pays installment payments of 2% of the entrance fee each month during the one year period, and the balance of the entrance fee at the end of the one year period. The outstanding balance of these receivables is recorded as entrance fee receivables on the combined statement of financial position. Entrance fees receivable amounted to $2,924,168 and $4,379,604 as of June 30, 2016 and 2015, respectively.

In March 2012, The Maryland Department of Aging approved a revised Residence and Care Agreement, which adds a 50% and 90% Refundable Entrance Fee option. The refundable portions of these entrance fees are within the Refundable Entrance Fees account and are not being amortized into income.

NOTE 9 EMPLOYEE BENEFIT PLAN

A defined contribution plan is available for all eligible employees of the Corporation. During the year ended June 30, 2015; and through the period ended December 31, 2015; the Corporation made matching contributions to each eligible participant in an amount equal to 100% of salary deferral up to 3%. The Corporation also made a discretionary contribution equal to 3% of each participant's compensation. On January 1, 2016, the Plan was amended to allow the Corporation to make matching contributions to each eligible participant in an amount equal to 100% of the first 3% of eligible compensation and 50% of the next 2% of eligible compensation. Additionally, discretionary contributions may be made. Contributions totaled $321,752 and $263,385 for the years ended June 30, 2016 and 2015, respectively. On July 22, 2015, the Plan was amended to allow employees who have completed 60 days of service and attained the age of twenty one to be eligible to participate in the salary reduction arrangement of the Plan, effective August 1, 2015.

NOTE 10 FUNCTIONAL EXPENSES

The Corporation provides various services to its residents. Expenses related to providing these services consist of the following for the years ended June 30:

	2016	2015
Program	$ 18,802,390	$ 17,994,336
Management and General	5,763,206	4,714,488
Fundraising	94,818	107,997
Total	$ 24,660,414	$ 22,816,821

NOTE 11 CAPTIVE INSURANCE PROGRAM

The Corporation participates in a captive risk retention group formed under the Federal Liability Risk Retention Group Act which is administered by Peace Church Risk Retention Group (PCRRG) (a reciprocal) for general and professional liability and excess liability insurance. Effective December 28, 2007, PCRRG converted from a stock insurance company to a reciprocal insurance exchange under the laws of the State of Vermont. The shares of stock in PCRRG were converted to a subscriber interest in the PCRRG Reciprocal. The subscriber's interest is recorded at cost which totals $187,580 at June 30, 2016 and 2015.

Primary insurance is provided by PCRRG and reinsured through Caring Communities, a reciprocal Risk Retention Group (CCrRRG). CCrRRG is an incorporated insurance company domiciled in Washington, D.C. PCRRG is a member of CCrRRG along with other insureds. PCRRG cedes reinsurance premiums to CCrRRG and shares risk on an excess of loss basis. CCrRRG's exposure is limited to an aggregate equal to 350% of the premium ceded.

NOTE 12 ENDOWMENT FUND

Interpretation of Relevant Law

The Corporation has interpreted the relevant state law as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment fund absent explicit donor stipulations to the contrary to retain any income earned on the original gift as long as they are prudent in their spending of endowment assets. As a result of this interpretation, the Corporation classifies as permanently restricted net assets the original value of gifts donated to the permanent endowment and the original value of subsequent gifts to the permanent endowment. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Corporation in a manner consistent with the standard of prudence prescribed by the relevant state law. Unless specifically defined, a donor-restricted endowment fund that is required by donor stipulation to accumulate or appropriate endowment funds, the Corporation considers the following factors:

(1) The duration and preservation of the fund.

(2) The purposes of the corporation and the donor-restricted endowment fund.

NOTE 12 ENDOWMENT FUND (CONTINUED)

Interpretation of Relevant Law (Continued)

(3) General economic conditions.

(4) The possible effect of inflation and deflation.

(5) The expected total return from income and appreciation of investments.

(6) Other resources of the corporation.

(7) The investment policies of the corporation.

The Corporation has adopted investments and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets.

Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity. Under this policy, the endowment assets are invested in a manner that is intended to produce results that exceed the performance of a weighted index comprised of certain funds as defined in the Board of Trustees' approved investment policy.

The Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends) to satisfy its long-term rate-of-return. The Corporation targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

The following schedule represents the endowment net asset composition by type of endowment fund as of June 30:

	2016			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment Net Assets -				
Beginning of Year	$ 14,004,250	$ 1,485,582	$ 3,832,402	$ 19,322,234
Investment Return	(87,400)	(41,983)	-	(129,383)
Contributions	48,458	-	-	48,458
Releases for Expenditure	(42,288)	(116,495)	-	(158,783)
Endowment Net Assets - End of Year	$ 13,923,020	$ 1,327,104	$ 3,832,402	$ 19,082,526

NOTE 12 ENDOWMENT FUND (CONTINUED)

	2015			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment Net Assets - Beginning of Year	$ 13,722,526	$ 1,486,892	$ 3,832,402	$ 19,041,820
Investment Return	226,252	88,699	-	314,951
Contributions	117,748	675	-	118,423
Releases for Expenditure	(62,276)	(90,684)	-	(152,960)
Endowment Net Assets - End of Year	$ 14,004,250	$ 1,485,582	$ 3,832,402	$ 19,322,234

The fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or the relevant state law requires the Corporation to retain as a fund of perpetual duration. In accordance with GAAP, these deficiencies are reported as unrestricted net assets. There were no deficiencies reported as of June 30, 2016 and 2015.

NOTE 13 FAIR VALUE OF FINANCIAL INSTRUMENTS

For assets measured at fair value on a recurring basis, the fair value measurements by level within the fair value hierarchy used as of June 30, 2016, are as follows:

Description	Total	Level 1	Level 2	Level 3
Cash and Cash Equivalents	$ 5,216,480	$ 5,216,480	$ -	$ -
Fixed Income Securities:				
Corporate Bonds - AAA to AA3 Bond Credit Rating	3,185,360	3,185,360	-	-
U.S. Obligations	5,381,516	5,381,516	-	-
Total Fixed Income Securities	8,566,876	8,566,876	-	-
Equity securities:				
Consumer Discretionary	1,939,644	1,939,644	-	-
Energy	1,176,211	1,176,211	-	-
Financial	3,047,243	3,047,243	-	-
Health Care	2,408,946	2,408,946	-	-
Industrial	1,396,418	1,396,418	-	-
Information Technology	3,146,543	3,146,543	-	-
Materials	484,432	484,432	-	-
Other	2,599,978	2,599,978	-	-
Total Equity Securities	16,199,415	16,199,415	-	-
Equity Mutual Funds	8,711,607	8,711,607	-	-
Fixed Income Mutual Funds	8,125,616	8,125,616	-	-
Alternative Investments	2,425,925	1,914,323	-	511,602
Total	$ 49,245,919	$ 48,734,317	$ -	$ 511,602

The above schedule does not include a $187,580 investment in a captive insurance program.

NOTE 13 FAIR VALUE OF FINANCIAL INSTRUMENTS (CONTINUED)

For assets measured at fair value on a recurring basis, the fair value measurements by level within the fair value hierarchy used as of June 30, 2015, are as follows:

Description	Total	Level 1	Level 2	Level 3
Cash and Cash Equivalents	$ 5,031,398	$ 5,031,398	$ -	$ -
Fixed Income Securities:				
Corporate Bonds - Aaa to Aa3 Bond Credit Rating	4,020,228	4,020,228	-	-
U.S. Obligations	5,900,005	5,900,005	-	-
Total Fixed Income Securities	9,920,233	9,920,233	-	-
Equity securities:				
Consumer Discretionary	2,056,519	2,056,519	-	-
Energy	1,169,377	1,169,377	-	-
Financial	3,072,169	3,072,169	-	-
Health Care	2,399,946	2,399,946	-	-
Industrial	1,389,405	1,389,405	-	-
Information Technology	3,009,794	3,009,794	-	-
Materials	529,790	529,790	-	-
Other	2,240,606	2,240,606	-	-
Total Equity Securities	15,867,606	15,867,606	-	-
Equity Mutual Funds	9,969,467	9,969,467	-	-
Fixed Income Mutual Funds	6,897,750	6,897,750	-	-
Alternative Investments	1,744,921	987,500	-	757,421
Total	$ 49,431,375	$ 48,673,954	$ -	$ 757,421

The above schedule does not include a $187,580 investment in a captive insurance program.

The following valuation techniques were used to measure fair value of each class of financial instrument as of June 30, 2016:

Cash and Cash Equivalents – The carrying amount approximates fair value because of the short-term nature of those investments.

Equity, Fixed Income, and Equity Mutual Fund Securities – Fair value of equity, fixed income, and equity mutual fund securities was based on quoted market prices for the identical security.

Alternative Investments – Fair value of alternative investments was based on net asset value per share (NAV). These assets are included as Level 3 fair values, based upon the lowest level of input that is significant to the fair value of measurement.

NOTE 13 FAIR VALUE OF FINANCIAL INSTRUMENTS (CONTINUED)

The following table summarizes the roll forward of Level 3 assets for the years ended June 30:

	2016	2015
Balance as of Beginning of Year	$ 757,421	$ 815,601
Realized Gains (Losses)	1,650	615
Withdrawals	(115,076)	(92,903)
Unrealized Gains (Losses)	(132,393)	34,108
Balance as of End of Year	$ 511,602	$ 757,421

The Corporation has a policy which permits investments in alternative investments that do not have a readily determinable fair value and, as such, uses the net asset value per share (the NAV) as calculated on the reporting entity's measurement date as the fair value of the investment. A listing of the investments held by the Corporation and their attributes that may qualify for these valuations consist of the following as of June 30:

	2016			
Investment/Strategy	Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
(a) Chesapeake Investments III Limited Partnership	$ 484,575	$ -	This Fund is a Closed End Fund with no Redemption Rights	N/A
(b) Collins Capital Low Volatility Performance II Special Investments, Ltd.	27,027	-	**	N/A

(a) The fund is a portfolio consisting primarily of U.S. properties, leases, mortgages and other real estate related interests (Properties). The Properties investment strategy will be to invest in properties that are mid-sized, generally requiring an equity commitment from the fund of approximately $2,000,000 to $7,000,000 and having a total cost of between $5,000,000 and $20,000,000 and will be those primarily requiring value-added services – enhanced management, development, redevelopment, rehabilitation, repositioning, and/or financial restructuring, and will typically be acquired through joint ventures with local and regional developers and operators. The Properties are expected to vary both in geographic sector and property type, with some of the Properties to be acquired before or during development, and others to be acquired during the lease-up or operational stages. Investment objective is to manage the portfolio of Properties with a goal of producing, through a combination of operating cash flow and asset appreciation, a low-teen pre-tax IRR, net of fees, expenses and carried interests.

NOTE 13 FAIR VALUE OF FINANCIAL INSTRUMENTS (CONTINUED)

(b) This fund was established to provide an alternative that offers liquidity as it becomes available from the underlying managers of the Collins Capital Funds. This special purpose vehicle (SPV) portfolio will be managed with the sole objective of converting all the underlying fund holdings to cash. As investments are liquidated, cash distributions will be made to participants in each SPV on a quarterly basis. The remaining SPV portfolios will, therefore, become increasingly concentrated. It is anticipated that, depending on the Fund, initial liquidations within the SPVs will generate approximately 20% to 30% disbursable cash at the end of the third quarter and an additional 10% to 15% in the fourth quarter, subject to change as more information is obtained from the underlying fund managers. Based on information currently received, however, it may take a minimum of two or three years to fully liquidate each SPV, although no assurances can be made to the actual timetable.

** The fund is a special purpose vehicle established to provide an alternative that offers liquidity to those who were invested in the Collins Capital Fund. See description of redemption plan at (b).

NOTE 14 SELF-INSURED HEALTH PROGRAM

The Corporation has set up a self-insured group health plan with Peace Church Health Insurance Program (PCHIP) effective January 1, 2013, replacing the previous premium-based plan. The Corporation assumes the risk for paying the health care claim costs up to $25,000 per participant per year. Additional claims above this amount for each individual are supported by PCHIP and the stop loss insurance of the Plan. In addition to coverage on the individual level, the Corporation has an aggregate stop loss policy with an estimated annual aggregate attachment point of $924,696, which represents the minimum amount the Corporation would be responsible for paying before aggregate stop loss reimbursements would become applicable.

Self-insurance costs are accrued based on claims reported as of the balance sheet date as well as an estimated liability for claims incurred but not reported (IBNR). The total accrual for self-insurance costs is $204,393 and $186,610 as of June 30, 2016 and 2015, respectively, which is included in Accounts Payable and Accrued Expenses in the Combined Statements of Financial Position.

The health plan is backed by an irrevocable letter of credit in the amount of $172,898. This letter of credit expires on July 30, 2017 and management is in the process of renewal.

NOTE 15 COMMITMENTS AND CONTINGENCIES

Master Plan

The Board of Trustees approved the expenditure of $4,000,000 for preliminary costs to start design, planning and presale activities related to Phase I of the Corporation's Master Plan. The first phase, estimated to commence construction on or about November 1, 2017 (subject to regulatory approvals), includes the construction of approximately fifty-two new hybrid independent living units, expansion and renovation of Assisted Living, the renovation of the skilled nursing area and other related improvements. As of June 30, 2016, contracts totaling $3,550,000 have been executed with various professional firms for services required to complete the preliminary stage activities. As of June 30, 2016, $1,926,000 of this total has been incurred and capitalized as Construction in Process.

Health and Wellness and Dementia Program Development

On May 15, 2015, the Corporation entered into an agreement with Johns Hopkins HealthCare, LLC on a collaborative engagement to develop, with Johns Hopkins physicians and scientists, centers of excellence in two critical areas of aging services: Dementia Care and Health & Wellness. The services will be consulting and advisory in nature and the cost for the services is estimated to be $340,000 over an 18 month period. The Corporation has paid $283,330 and $0 for the services as of June 30, 2016 and 2015, respectively.

Matricciani, Rose M.

From: John Peacock <JPeacock@archltd.com>
Sent: Tuesday, March 14, 2017 1:43 PM
To: Matricciani, Rose M.; Robin Somers; John Palkovitz
Cc: Brit Vipham
Subject: Broadmead CON Project description
Attachments: item 11 - Project description DRAFT 03142017 wo schedule.docx

As per our call, we took shot at the project description based on the MDOA submission and changing it to be more oriented to nursing care.

Please review and make any adjustments for Andy.

John J Peacock, ALA, Principal

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Project Description:

Broadmead, Inc. is a not-for-profit, Maryland non-stock Corporation. The sole member of the corporation is Friends Care, Inc., also a not-for-profit, Maryland non-stock Corporation. Friends Care, Inc. is located at 13801 York Road, Cockeysville, Maryland 21030. Broadmead, Inc. is a qualified tax-exempt organization as described in Section 501(c) (3) of the Internal Revenue Code.

Broadmead consists of 70 licensed skilled nursing beds, containing administrative offices, recreational, meeting and dining amenities, 30 licensed assisted living beds, and 265 independent living residences (249 garden homes and 16 apartments) together with a central building (the Broadmead Center). Beginning in 2011, and with the approval of the Maryland Department of Aging, Broadmead offered up to nine of its garden home residences to seniors on a rental basis only (6 rentals as of the date of submission). As the term of these rental agreements end (through April, 2019) or are terminated, the rental units will revert back to continuing care units. Broadmead is accredited by CARF/CCAC (Commission on Accreditation of Rehabilitation Facilities/Continuing Care Accreditation Commission).

Broadmead's Mission Statement

To foster independence, growth and the opportunities in elderhood by supporting a dynamic community, providing exceptional health services, developing collaborative relationships and upholding Quaker values.

Broadmead's Vision Statement

To be a leader in the development of high quality, innovative solutions that enrich the lives of older people, promote relationships, and create opportunities as it extends its mission of service in the Quaker tradition.

In 2014, with the appointment of a new CEO and Executive Leadership team, the Board of Trustees embarked on developing a comprehensive and progressive strategic plan for the 36 year old Broadmead community. As a result of multiple market studies, a Resident Satisfaction Survey, an Employee Satisfaction Survey, and engaging stakeholders in focus groups, four key organizational strategic goals were identified:

Goal 1. Provide Exceptional Senior Living Services and Superior Healthcare to our Residents;

Goal 2. Establish and Maintain a Person-Centered Culture that Respects the Independence, Choice and Dignity of Each Individual;

Goal 3. Create Centers of Excellence in Programs and Environments in Senior Living and Healthcare; and

Goal 4. Expand Programs to a Broader Socio-Economic and Culturally Diverse Population of Older Adults.

A Master Plan has been created to support these four organizational strategic goals through repositioning and renovating the campus. The Master Plan will include the following:

A. Relocation and redesign of the campus entrance off of York Road;
B. Expanded parking for residents, employees, and visitors;
C. Renovation of current common areas to create a new Bistro, Resident Library, Resident meeting rooms, Resident Association offices, relocation of the Resident Association's "Country Store," relocation of Broadmead's convenience store, and renovation of the Auditorium;
D. Expansion and renovation of the Holly Terrace Dining Room to include an additional private dining room, additional seating, enhanced meal service, and storage for mobility devices;
E. Creation of dedicated space to support a Center of Excellence for Health and Wellness, through the renovation of vacated independent living apartments;
F. Replacement of the existing pool with a new and enlarged indoor pool with renovated and enlarged changing rooms and showers;
G. Relocation of the Finance Department and the Board Room;
H. Relocation of the Resident Art Studio, Ceramics Studio, and Salon;
I. Addition of a new Memory Support Assisted Living household, with 14 new licensed AL beds;
J. Renovation of comprehensive care space to include a new 17-bed dedicated short term rehabilitation household, a 13-bed skilled nursing dementia care household, a 27-bed skilled nursing long term care household; and a 13-bed skilled nursing household adjacent to the existing assisted living household;
K. Addition of two new independent living apartment buildings, consisting of 26 homes in each building with lower level, covered parking;
L. Minor renovation of interior finishes of the first floor of the historic Holly House;
M. Addition of a one-story maintenance building.

Design and Description of Work

The Broadmead project that addresses the objectives of their Master Plan will consist of the renovation of health care areas, assisted living areas, common areas, staff areas, and additional independent living apartments.

The number of proposed existing and additional units per type for the entire campus is as follows:

Unit Type	Existing	Expansion	Total
Independent Living			
- Hillside Homes	0	52	52
- Stony Run 1st Floor	7	-7	0
- Stony Run 2nd Floor	9	-9	0
- Clustered Cottages	249	0	249
Total IL	265	36	301
Skilled Nursing			
Total Licensed Beds	70	0	70
Assisted Living			
- Second Floor Assisted Living Dementia Care (14 private rooms)	0	14	14
- Third Floor Assisted Living	30	-2	28
Total AL	30	12	42

Broadmead is currently approved for 70 skilled nursing beds that were granted through a certificate of need ("CON") from the Maryland Health Care Commission. The 70 skilled nursing beds serve Broadmead residents and the general public, and will be retained for the purpose of this project. To renovate its facilities and upgrade its services, Broadmead will engage in a capital project to renovate and expand the skilled nursing areas without increasing the number of licensed skilled nursing beds.

The renovation project will include the development of four neighborhoods of traditional nursing clusters, one of which will be dedicated to the support of residents in the later stages of dementia. Each neighborhood will be provided with dining, an activity kitchen and social spaces. Two of the neighborhoods will have direct access to an exterior courtyard. In addition, 17 of the 70 licensed skilled beds will be dedicated for a short term rehabilitation neighborhood. This neighborhood will have all private rooms with private bathrooms and European showers, ample dining and living room space, and direct elevator access to the physical therapy gym.

The Broadmead project consists of the follow areas:

A. Broadmead Center

1. Third Floor (Assisted Living and Skilled Nursing); See Addenda 1B for Broadmead Center's existing and proposed Third Floors Plan for Assisted Living & Skilled Care.

a. Assisted Living
Assisted Living is located on the third floor of the existing health center building and provides 30 licensed beds in 28 assisted living apartments. The project includes a dining area, activities kitchen and social spaces for the assisted living residents who will now have the chance to dine on their floor in a household setting, rather than having to travel to the café or main dining room on another floor. Other modifications include renovations to accommodate additional staff offices.

b. Skilled Care
An 11 room (13 bed), traditional skilled nursing household will be provided with dining, an activity kitchen and social spaces. Two of the rooms are designed to be shared to accommodate couples. This neighborhood is in a proposed addition expanding the existing health center building located on the second floor.

2. Second Floor (Skilled Nursing, Skilled Nursing Dementia Care, Rehabilitation and Assisted Living Dementia Care); See Addenda 1C for Broadmead Center's existing and proposed Second Floor Plan for Skilled Nursing, Skilled Nursing Dementia Care, Rehabilitation, and Assisted Living Dementia Care.

a. Skilled Nursing
Traditional skilled nursing is located on the second floor of the existing health care center and provides accommodations for residents needing skilled nursing services (40 beds). The project includes the development of two households of traditional skilled nursing in clusters of 10 and 13 rooms, respectively. The typical resident room will be a private room with a bathroom. Four of the rooms are designed to be shared and will include a bathroom. To promote a social model of care, each household will be provided with dining, an activity kitchen and social spaces organized around an exterior courtyard. The courtyard will provide access to the outdoors and natural light. To facilitate the proposed modifications, an addition is planned to the west side of the existing building. Broadmead currently has 70 skilled licensed beds. The project maintains the existing 70 beds with no new beds being requested.

b. Skilled Nursing Household
An 11 room (13 bed), skilled nursing household will be developed to meet the needs of residents with a diagnosis of dementia. The household residents will be provided with dining, an activity kitchen, social spaces and direct access to a secure outdoor courtyard. Two of the rooms are designed to be shared to

accommodate couples. To facilitate the proposed modifications, an addition is planned to enlarge the northeast wing of the existing skilled nursing building.

c. Rehabilitation
A 17 bed rehabilitation household will be developed as part of the project. This household will be designed to cater to the needs of residents seeking short-term rehabilitation services and will include dining and social spaces appropriately sized for this short-term stay population. The rehabilitation household will have direct elevator access to the recently renovated physical therapy gym. All resident rooms will be private.

d. Assisted Living Dementia Care
An existing independent living apartment floor will be converted to a new secure 14 room, assisted living, memory support household. This household will be designed to accommodate earlier stage dementia care residents in an assisted living setting. The household will include dining, activity kitchen, social spaces and common space amenities. A secure rooftop terrace will be provided for resident access to exteriors and natural light in the common areas. An interior loop circulation path will be provided in accordance with dementia programming best practices.

e. Resident Rooms
All skilled nursing resident rooms, unless otherwise noted, will be private rooms with private bath accommodations. All bathrooms will have European style, zero threshold showers, medicine cabinets and storage areas. The resident bedrooms will be provided with large windows, nurse serveries, indirect lighting features and individually controlled heating and cooling.

3. Life Enrichment Center (Broadmead Center)
The Life Enrichment Center is the social center of the community. The existing building houses office, dining, meeting, fitness, entertainment, and recreation facilities on two floors. The project consists of the following work; See Addenda 1D for the existing and proposed Life Enhancement Center's Lower Level & First Floor plans.

a. Lower Level
The lower level floor is the main entry to the community for the general public and visitors. To enhance the existing park-like setting and improve wayfinding, a new vehicular boulevard will provide a clear and direct path to the main entrance. Additional parking and landscape upgrades will also be incorporated. A new drop-off canopy will be provided for ease of access to the building.

The lower level will be renovated to provide an additional bistro/coffee shop dining area. This will provide a third dining venue for the community in a casual setting. The bistro will have access to an underutilized patio and courtyard area. The dining space will also incorporate resident meeting and social spaces including "The Corner Cupboard," a market relocated to the bistro area to

promote additional use and operational efficiencies. The remaining lower level space will be renovated to accommodate various resident association activities, meeting spaces, a country store, wood shop, a new elevator and a relocated library. The marketing suite will be renovated and remain in its current location.

b. First Floor
The first floor contains the main dining venues, production kitchen, wellness spaces, an auditorium and administrative offices. The Holly Terrace, the formal dining area, will be expanded to provide 60 additional seats and an additional private dining room. A new salad bar and reconfigured food service line will be part of the project.

The existing auditorium will be expanded to increase capacity in a more efficient seating layout. The additional space will be provided by relocating the existing library to the lower level. A new stage with an accessible ramp, green room and storage areas will be included. Audio-visual technology upgrades are also included in the plans.

The wellness center will be designed to promote a center of excellence program. The existing pool will be renovated and expanded to provide for additional resident aquatic programming. A dedicated fitness and aerobics space will provide for expanded wellness opportunities. A new locker area, with private showers and changing areas, as well as a family changing room have been included in the plans. The salon is being relocated from the lower level into the wellness area and reconfigured in a spa-like setting to include massage suites.

An art and ceramics studio with gallery space will be relocated at the entrance to the wellness center to reinforce the desired holistic approach to wellness. The existing clinic will be selectively modified to accommodate additional treatment rooms and an expanded waiting area. The remaining areas of the first floor will be renovated to accommodate administrative services including advancement, finance and a new board room.

B. Holly House and Maintenance Building; See Addenda 1E for the existing and proposed plans for the Holly House and Maintenance Building.

1. Holly House
The existing Holly House will be maintained for resident use including meetings and social events. Renovations will be made to update finishes, lighting and environmental systems on the first floor.

2. Maintenance Building
An addition is planned for the east side of the existing maintenance building to accommodate additional maintenance storage needs.

C. Hillside Homes (Independent Living)

The project includes the addition of 52 independent living units clustered in two new buildings located on the northwest side of the existing site. The two "Hillside Homes" structures encompass 26 apartments, each with units ranging in size from 1,065 to 1,555 square feet. Each building will have under-building parking and provide commons and apartment unit amenities to maintain a strong marketing advantage in the region. The Hillside Homes will be connected by an open, covered walkway to the community commons building. See Addenda 1A for the Hillside Home building and unit plans.

TAB 8

FINANCING LETTER

Ziegler
CAPITAL :: INVESTMENTS :: ADVICE

200 South Wacker Drive
Suite 2000
Chicago, IL 60606
Phone: 312-705-7258
www.ziegler.com

March 27, 2017

Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

RE: Broadmead Certificate of Need Application

Dear Mr. McDonald,

Ziegler is a nationwide investment banking firm that works with senior living organizations such as Broadmead to obtain financing for capital projects. I am writing in regard to the above referenced Certificate of Need application. I have been working with Broadmead on the financing of this project and Ziegler is interested in continuing to work with Broadmead on the financing of this project. We are confident that Broadmead will obtain adequate financing of the approximately $77.5 million requested to implement the project, including design, marketing, legal, contingency, development and construction costs, as well as the refunding of prior debt outstanding.

Sincerely,

Amy Castleberry

Amy Castleberry, CFA
Director

TAB 9

LETTERS OF SUPPORT

KEVIN KAMENETZ
County Executive

March 27, 2017

Mr. Ben Steffen, Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Broadmead

Dear Mr. Steffen:

I am writing to express my support for the Certificate of Need application filed by Broadmead to replace and relocate its nursing facility. Broadmead is a high-quality life care community, caring for older adults living independently, with assistance, and in its skilled nursing facility. It needs approval of this project in order to continue its excellent care of seniors. Broadmead must have a "state of the art" nursing facility in order to continue meeting the growing needs of our aging population.

Broadmead is a responsible provider, cost-conscious and fiscally responsible. Residents look to Broadmead for information, prevention, and treatment services.

I support this project and hope that the Commission approves Broadmead's CON application.

Very truly yours,

Kevin Kamenetz
County Executive

KK:clp

cc: Robin Somers, COO, Broadmead Inc.

Historic Courthouse | 400 Washington Avenue | Towson, Maryland 21204-4665 | Phone 410-887-2450 | Fax 410-887-4049
kevin@baltimorecountymd.gov | www.baltimorecountymd.gov

JAMES BROCHIN
Legislative District 42
Baltimore County

Judicial Proceedings Committee
Executive Nominations Committee
Joint Committee on Legislative Ethics

Chair
Baltimore County Senate Delegation

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Annapolis Office
James Senate Office Building
11 Bladen Street, Room 521
Annapolis, Maryland 21401
410-841-3648 · 301-858-3648
800-492-7122 Ext. 3648

District Office
Beltway Professional Building
1134 York Road, Suite 203
Lutherville-Timonium, Maryland 21093
410-823-7087

March 24, 2017

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Broadmead

Dear Mr. Steffen:

I am writing to express my support for the Certificate of Need application filed by Broadmead to replace and relocate its nursing facility.

Broadmead is a high-quality life care community, caring for older adults living independently, with assistance, and in its skilled nursing facility. Broadmead's vision is to be a leader in the development of high quality, innovative solutions that enrich the lives of older people and promote relationships. As such, Broadmead needs approval of this project in order to continue its excellent care of seniors. The plans for this "state-of-the-art" modernization are timely and necessary for them to continue meeting the growing needs of our aging population in Baltimore County.

I support this project and hope that the Commission approves Broadmead's Certificate of Need application. Should you have any questions regarding my support of their application, please feel free to contact me direction.

Sincerely,

Senator James Brochin
42nd Legislative District

cc: Robin Somers, COO, Broadmead Inc.

UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER

March 23, 2017

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Broadmead

Dear Mr. Steffen:

I am writing to express my support for the Certificate of Need application filed by Broadmead to replace and relocate its nursing facility. While Broadmead is a high quality life care community, it also cares for more than its life care residents. It needs this project in order to keep residents of the Baltimore region healthy. Broadmead must have a "state of the art" nursing facility in order to continue meeting the growing needs of our residents in this new century.

Broadmead requires new patient rooms in order to meet our population's needs. It has proven itself to be a responsible provider which is cost conscious and fiscally responsible. Residents look to Broadmead for information, prevention, and treatment services. It must be able to meet these needs.

I support this project and hope that the Commission approves Broadmead's CON application.

Sincerely,

Paul Nicholson
Senior Vice President
Chief Financial Officer

cc: Robin Somers

GBMC HealthCare System

Greater Baltimore Health Alliance
Greater Baltimore Medical Center
Gilchrist Hospice Care

John B. Chessare, M.D., MPH, FACHE
President & CEO

Office: 443-849-2121
Fax: 443-849-8679
jchessare@gbmc.org

March 30, 2017

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Broadmead

Dear Mr. Steffen:

I am pleased to offer my support for the Certificate of Need application submitted by Broadmead to modernize its nursing facilities. The plans for this modernization are timely and necessary. Broadmead is a high quality life care community, and it serves many people in the Baltimore region. Additionally, I find Broadmead's plans to be practical and fiscally conservative.

The nursing care needs of the residents of Baltimore County are best served with state-of-the-art facilities that anticipate the growing demands of our aging population. I hope that you will approve Broadmead's Certificate of Need application.

Sincerely,

John B. Chessare MD

John B. Chessare MD

cc: Robin Somers
Broadmead
Chief Operating Officer

BROADMEAD MACCRA CHAPTER

Protecting the Future of Continuing Care Residents

Voice of CCRC Residents at Annapolis

March 29, 2017

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Broadmead

Dear Mr. Steffen:

As an officer of the Broadmead Maryland Continuing Care Residents Association (MaCCRA) chapter in the capacity of legislative chair and the 2016-17 State MaCCRA President, I am pleased to offer my support for the Certificate of Need application submitted by Broadmead to a renovated health care center including a dementia center. The plans for this renovation are timely and necessary. Broadmead is a high quality life care community, and it serves many people in the Baltimore region. Additionally, I find Broadmead's plans to be practical.

The health care needs of the residents of Baltimore County are best served with state-of-the-art facilities that anticipate the growing demands of our aging population. I hope that you will approve Broadmead's Certificate of Need application.

Sincerely,

Alma Smith

Alma Smith
Broadmead MaCCRA Chapter
Legislative Chair
State MaCCRA President

cc: Robin Somers, COO, Broadmead Inc.

DELEGATE SUSAN L.M. AUMANN
Legislative District 42B
Baltimore County

ASSISTANT MINORITY LEADER

Economic Matters Committee
Banking, Economic Development, Science and Technology Subcommittee
Consumer Protection and Commercial Law Subcommittee

Joint Committee on Legislative Ethics

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

The Maryland House of Delegates
6 Bladen Street, Room 201
Annapolis, Maryland 21401
410-841-3258 · 301-858-3258
800-492-7122 *Ext.* 3258
Fax 410-841-3163 · 301-858-3163
Susan.Aumann@house.state.md.us

Date March 28, 2017

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Certificate of Need Application for Broadmead

Dear Mr. Steffen:

Broadmead Retirement Community was founded in 1979 and has since served the needs of retired people in its continuing care community. It has been highly sought after because of the excellent care and exceptional health services they provide. It is located in northern Baltimore County in Legislative District 42 B. Broadmead offers many social opportunities with a goal of nourishing the mind, body and soul. I am pleased to offer my support for the Certificate of Need application submitted by Broadmead to modernize its nursing facilities. The plans for this modernization are timely and necessary.

The nursing care needs of the residents of Baltimore County are best served with state-of-the-art facilities that anticipate the growing demands of our aging population. I hope that you will approve Broadmead's Certificate of Need application.

Sincerely,

Susan L.M. Aumann

Delegate Susan Aumann
District 42b, Baltimore County

cc: Robin Somers, COO, Broadmead Inc.

TAB 10

AFFIRMATIONS

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

Signature 

Date 4/3/17

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

Ann Patterson
Signature

4/3/2017
Date

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

Signature

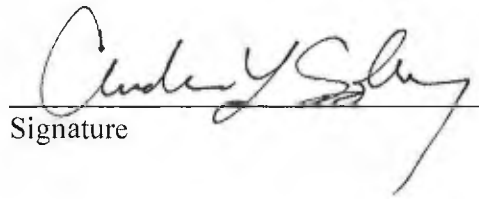
Date 4/3/17

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

Signature

Date 4/3/17

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



Signature

4/3//2017

Date

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

Signature

April 2, 2017

Date