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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: Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community
Application for CON to Purchase Beds

Dear Ms. Potter:

Please be advised that I represent Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community and am filing, on its behalf, its CON application to Purchase Beds.

Enclosed please find six (6) binders containing the Table of Contents, application, CON Tables, Discharge Materials, Whole Building Design Guide, Quality Materials, most recent Consolidated Financial Statements December 31, 2015 and 2014, letters of support and affirmation statements.

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

Rose M. Matricciani

RMM:mrm

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

1. Application
2. CON Table Package
3. Discharge Materials
4. Whole Building Design Guide
5. Quality Materials
6. Consolidated Financial Statements December 31, 2015 and 2014
7. Letters of Support
8. Affirmation Statements

cc: Peter Dabbenigno, Executive Director
Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community

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

2240995

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James F. Bernardo, Executive Vice President and Chief Operating Officer
Presbyterian Senior Living, Inc.
Dan Davis, MS, MHA,Vice President Continuing Care Operations
Presbyterian Senior Living, Inc.
Peter Dabbenigno, Executive Director
Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community
Donna Casner, Vice President & Controller
Presbyterian Senior Living, Inc.
Michelle Hollis, Assistant Controller
Presbyterian Senior Living, Inc.
Andrew L. Solberg, Healthcare Consultant
A.L.S. Healthcare Consultant Services

Presbyterian Senior Living Services, Inc.
d/b/a Glen Meadows Retirement Community

Application for CON
to
Purchase Beds

Tabs

1. Application
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2240785

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: Glen Meadows Retirement Community

Address:

11630 Glen Arm Road	Glen Arm, MD	21057	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.

Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community is a not-for-profit, Maryland non-stock Corporation. The sole member of the corporation is Presbyterian Senior Living, Inc. located at One Trinity East Drive, Suite 201, Dillsburg, PA 17019. Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community is a qualified tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. Therefore, no person has an ownership interest in Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community.

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:

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 3/30/1998
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: Peter Dabbenigno, Executive Director

Company Name Presbyterian Senior Living Services, Inc., d/b/a Glen Meadows Retirement Community

Mailing Address:

11630 Glen Arm Road	Glen Arm	21057	MD
Street	City	Zip	State

Telephone: 410-319-5122

E-mail Address (required):
PDabbenigno@psl.org

Fax: 419-319-5015

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
Glen Meadows Retirement Community, Inc.

Address:

11630 Glen Arm Road	Glen Arm	21057	MD	Balto.
Street	City	Zip	State	County

Telephone: 410-319-5000

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

Glen Meadows Retirement Community, Inc. is a not-for-profit, Maryland non-stock Corporation. The sole member of the corporation is Presbyterian Senior Living Services, Inc., d/b/a Glen Meadows Retirement Community located at 11630 Glen Arm Road, Glen Arm, MD 21057. Glen Meadows Retirement Community, Inc. is a qualified tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. Therefore, no person has an ownership interest in Glen Meadows Retirement Community, 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

Seller: Presbyterian Home of Maryland, Inc. d/b/a Carsins Run at Eva Mar

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:

400 Georgia court	Towson	21204	MD	Baltimore
Street	**City**	**Zip**	**State**	**County**

Telephone: (410) 823-4622

NOTE: Once Glen Meadows purchases the beds, it will have the rights to sell the beds.

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 Presbyterian Senior Living, Inc.

Address:

One Trinity East Drive, Suite 201	Dillsburg	17019	PA	Baltimore
Street	City	Zip	State	County

Telephone: 800-382-1385

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

NOTE: None of these apply. GM is proposing to include admissions from the public into its existing beds and not be restricted to only CCRC admissions

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

Conversion of 22 existing CCRC Beds to public beds through the purchase and relocation of 22 Temporarily De-Licensed public beds from Presbyterian Home.

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

GLEN MEADOWS RETIREMENT COMMUNITY

Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community 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.

Glen Meadows Retirement Community is a continuing care retirement community ("CCRC") located on over 480 acres of woodland, wetlands and tillable fields in Glen Arm, Baltimore County, Maryland. Glen Meadows offers seniors three choices in levels of living:

- Independent Living – 113 patio homes and 83 apartments
- Personal Care – 36 private rooms and 4 semi-private
- Skilled Nursing – 31 licensed beds

The patio homes surround the Manor House, the original building on the campus, to which they are connected by covered walkways or walking paths. Apartments and personal care suites are located in the Manor House along with the dining room, exercise and meeting rooms, a physician's clinic and beauty shop, and staff offices. Adjacent to the original building, we offer our residents private or semi-private skilled nursing care in our health center that was added in the 1980's on one floor and Assisted living on the 2nd floor.

Glen Meadows ("GM") offers residents support in their successful aging process by partnering with Masterpiece Living – a program centered on staff and resident-led activities that promote physical, intellectual, social, and spiritual well-being. Our 139 employees (73 full time and 66 part time) provide quality care and meaningful social interaction with every one of our residents who depend upon their skill and training to assist residents as they age in place.

GM has been operating at a loss for several years, as Table F in the CON Application Table Package shows.

	CY 2015	CY 2016	CY 2017
NET INCOME (LOSS)	-$954,983	-$656,563	-$431,061

Over that time, GM has been meeting with the Maryland Department of Aging ("Department") to create solutions to its financial situation and to explore ways to make the Community more fiscally sound and independent. Noting that the skilled nursing beds were not being fully utilized by the continuing care residents of GM because of the community-based services available to the residents, it was a suggestion of the Maryland Department of Aging that the facility could boost its revenues by purchasing skilled nursing beds from another provider which had a Certificate of Need ("CON") for its skilled nursing beds. The facility took this recommendation seriously and looked at

the market with regard to purchasing skilled nursing beds. By not increasing the number of beds and using its unfilled beds for outside admissions, Glen Meadows could increase its financial viability without making costly renovations or incurring additional construction costs. Therefore, when the opportunity arose with Presbyterian Home of Maryland, Inc. d/b/a Carsins Run at Eva Mar to purchase their delicensed beds, GM immediately entered into negotiations to purchase these CON beds pending approval from the Maryland Health Care Commission.

While GM has purchased 22 temporarily delicensed beds from Presbyterian Home of Maryland, Inc. d/b/a Carsins Run at Eva Mar, it is not proposing to increase its bed capacity. Rather, it is proposing to allow up to 22 of its 31 beds as CCRC/Public beds. Because GM must guarantee that adequate beds are available for its CCRC residents, GM anticipates using only 10 of these beds for non-CCRC patients needing skilled care.

It is crucial that GM be allowed to do this purchase in order to drive the facility back into profitability. GM projects that the additional revenue will allow GM to have positive net income within two years because of it.

	CY 2017	**CY 2018**	**CY 2019**	**CY 2020**
NET INCOME (LOSS)	-$431,061	-$366,813	$89,943	$700,931

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

Please see Tab 2 which includes the entire CON Application 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.

Currently GM provides residential service agency services, social work services, meal and transportation services as well as outpatient physical therapy to residents who are discharged from the nursing center back to independent living at the CCRC. If CCRC residents require Home Health Services, those services are typically provided by Bayada Home Health Services. GM also provides access to other community-based services, if requested, such as adult day care and hospice care. The following community-based providers are utilized:

Stella Maris – Adult Day Care
Bayada – Home Health Services
Gilchrist Hospice – end of life care
Arden Court – specialized memory support (dementia services)
Brightview – memory support (dementia services)
Chesapeake Home Care – support for activities of daily living.

None of these services will be affected by this project.

14. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 483 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 X NO _____ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

There are no required approvals.

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

(1) Owned by: Glen Meadows Retirement Community, 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	N/A	months
Initiation of Construction within 4 months of the effective date of a binding construction contract	N/A	months
Time to Completion of ~~Construction~~ Project from date of ~~capital obligation~~ approval.	3	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.

Not applicable. This project involves neither new construction nor renovation.

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)

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 already 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.)

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.

   Peter Dabbenigno, Executive Director

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.

Presbyterian Senior Living, Inc. has been involved in developing and managing the following skilled nursing health care facilities: PA facilities - Cathedral Village, Green Ridge Village, Kirkland Village, Presbyterian Village at Holidaysburg, St. Andrews Village, Ware Presbyterian Village, Westminster Village in Allentown, Westminster Woods at Huntingdon, Windy Hill Village; DE facility – Westminster Village in Dover.

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.

4-4-2017
Date

Peter J. Dabbenigno
Signature of Owner or Board-designated Official

Executive Director
Position/Title

Peter J. Dabbenigno
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:<u>http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp</u>

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.

GM already participates in the Medical Assistance Program for skilled care continuing care residents who have "spent down" their assets, enabling GM to receive Medicaid reimbursement for CCRC residents who qualify. GM will sign the MOU prior to seeking first use review. The most recently published applicable Medicaid percentage requirement (*Maryland Register*, 2/5/2016, p. 303) is 42.5 percent. GM agrees to meet all of the requirements of this standard in regard to the patient days generated by admissions from the public. GM will not count any Medicaid days generated by GM 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.

Because GM currently does not have the ability to admit patients who are not already continuing care members at GM, it is not required to provide information to its continuing care residents about the existence of alternative community-based services if they are prospective comprehensive care patients. GM commits that, once it can admit residents from the public, it will provide information to all prospective residents about the existence of alternative community-based services, including but not limited to, Medicaid home and community-based waiver programs, home care, medical day care, assisted living, and other initiatives to promote care in the most appropriate settings.

GM initiates discharge planning on admission as part of its development of the Resident Care Plan. Please see Tab 3, which includes GM's Discharge Planning Policy and Transfer and Discharge Process.

GM 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.

Currently Glen Meadows provides residential service agency services, social work services, meal and transportation services as well as outpatient physical therapy to residents who are discharged from the nursing center back to independent living at the CCRC. If CCRC residents require Home Health Services, those services are typically provided by Bayada Home Health Services.

(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**

All staff upon initial hire and annually will receive training that addresses the psychosocial problems facing nonelderly disabled residents. Glen Meadows currently uses Relias training module which is required to be completed by its employees on an annual basis. In addition, Glen Meadows will develop a curriculum with its psychiatric provider, Med Options, along with its licensed social worker which specifically addresses the needs of non-elderly residents.

(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.**

It is GM's practice to initiate discharge planning immediately following admission with the goal of limiting length of stay in order to facilitate discharge to the least

restrictive living environment as soon as possible for all residents.

GM's connection with community-based programs facilitates earlier discharge by providing referral resources to assist in addressing residents' at-home needs. A specific discharge plan is completed for each resident based upon their personalized needs and desires. Residents and family members/personal representatives receive appropriate education and provide input into the discharge planning.

(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.

Not applicable. This project does not involve new construction or renovation.

(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.**

GM has its own water and sewer plant that has been inspected and licensed by Maryland .

(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.

An interdisciplinary team develops programs for residents, and the plan of care incorporates the resident's individualized needs and desires. The care plan for younger residents will incorporate access to programs and materials that will be age-appropriate to meet the resident's needs. For example, GM provides reading materials, access to outdoor areas, a calendar of events and social activities, exercise room, beauty shop, dining room, gift shop, and library/computer room.

The Skilled Nursing Facility at Glen Meadows Retirement Community will continue to serve the same types of diseases/illnesses it has served traditionally. This will include residents requiring the needs of the facility as determined by a licensed physician. These residents could have any of, but not necessarily limited to, the following conditions:

- CHF
- COPD
- MI
- Dementia
- ORIF
- Total Hip Replacement
- Total Knee Replacement
- Diabetes
- Renal Disease
- Cancer
- End of life care
- Cardiac Disease other than MI
- Wound care
- CVA

In order to provide appropriate levels of care to these types of residents, GM's staff is trained to provide the following services:

- IV Therapy
- Rehabilitation Therapy
- Respiratory Services (Tracheostomy, Chest Tubes, Chest PT, Oxygen Therapy)
- Wound Care Services
- IV Therapy
- Total Parenteral Nutrition (TPN)

- Enteral Nutrition
- Pain Management
- Vital-Stim for Dysphagia

The design of the skilled nursing facility is consistent with the National Institute of Building Sciences in its 2011 revision of their Whole Building Design Guide for skilled nursing facilities. (See Tab 4.)

(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 GM'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.**

Glen Meadows is a Continuing Care Retirement Community that currently provides Skilled Nursing, Assisted Living, and is a Residential Services Agency licensed by the state of Maryland to provide supportive home care services.

In addition to the services directly provided by Glen Meadows, we also work with:

- Stella Maris Adult Day Care Center - the day program is designed to combine health services and social activities in order to help individuals stay mentally and physically active, reduce isolation and prevent decline;
- Stella Maris Hospice - provides end of life care and services;
- Bayada Home Health Services - provides services in the person's home such as assisting with ADLs and safely managing tasks around the home, companionship, therapy and rehabilitative services and short or long-term nursing care for an illness, disease or disability;
- Gilchrist Hospice - provides end of life care and services;
- Arden Court - provides specialized memory support and care (dementia services);
- Brightview - provides specialized memory support and care;
- Greater Baltimore Medical Center - provides inpatient and outpatient care;
- University of Maryland St. Joseph's Medical Center - provides inpatient and outpatient care; and
- Franklin Square Medical Center - provides inpatient and outpatient care.

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.**

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, GM 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, GM 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. GM'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).

GM 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.

GM 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. GM applied the appropriate step as identified by the MHCC.

However, for persons who received care in Baltimore County from Out of State, GM 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,*

GM 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 GM 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

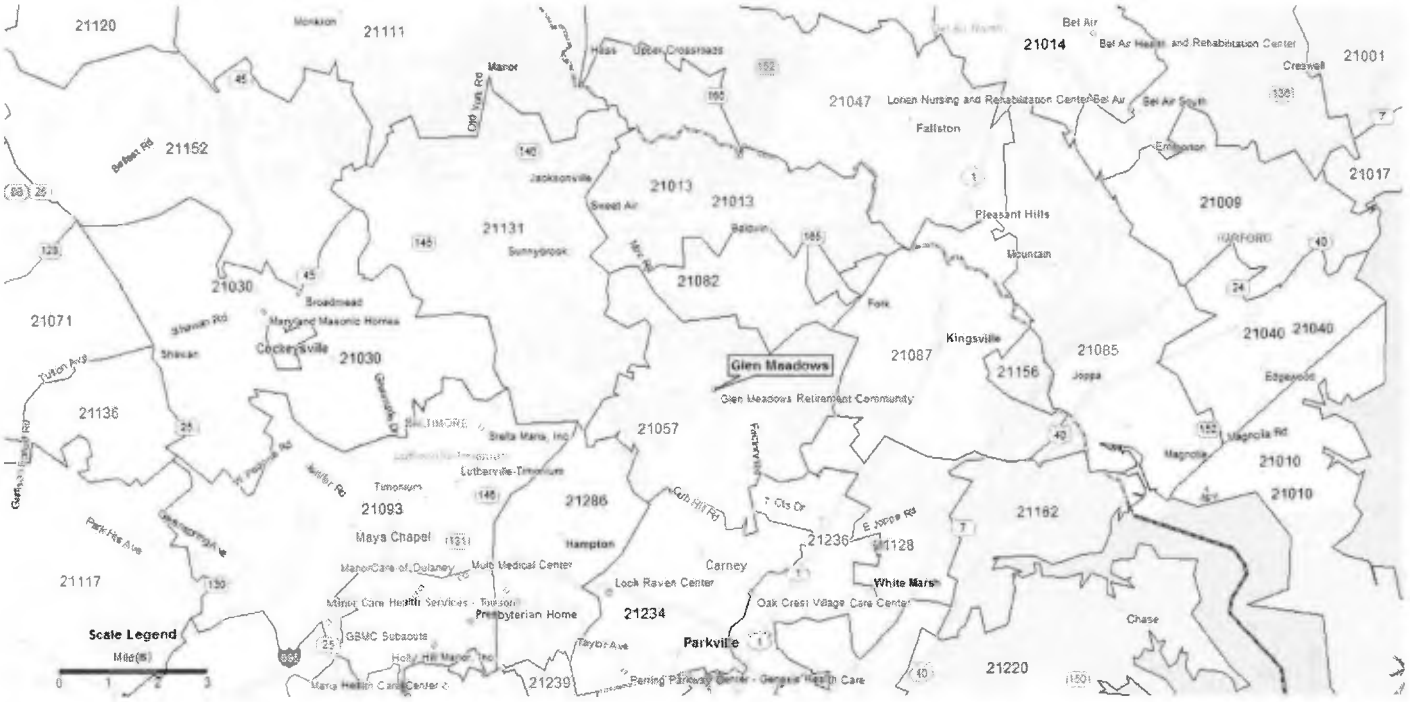
GM recognizes that the MHCC methodology still shows a bed excess in Baltimore County. The point of presenting this is that these projections show that, compared to the "current" MHCC bed need projections for 2016, people will need 523 additional beds than were projected for 2016. That constitutes a substantial reduction in the bed excess. GM'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

In addition, allowing GM to admit people from the public will improve access in the northern areas. Figure 1 is a map of northeast Baltimore County and shows the location of Comprehensive Care facilities in that region of the county. It shows all of the facilities are located to the south and west of GM, with no other facilities located in GM's Zip Code and north. This would allow for a re-distribution of existing beds already in the MHCC's bed inventory. It would result in residents of this section of the county having a choice to go to a high quality facility that is closer to their homes.

Figure 1

Baltimore County Comprehensive Care Facilities



(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.

Year	Occupied Days	Bed Days Available	Occupancy %
2016	8,046	11,346	71%
2015	10,004	11,315	88%

Occupancy in Glen Meadows Retirement Community's health center has been impacted by a number of care delivery and reimbursement initiatives over the past few years. As a result, the health center at Glen Meadows Retirement Community has excess capacity to provide services to non-CCRC residents. These initiatives include:

Centers for Medicare and Medicaid Services has implemented various initiatives that incentivize (or penalize) acute care providers to provide services to beneficiaries

more efficiently. This has resulted in Medicare beneficiaries not obtaining a 3-day qualifying hospital stay to trigger a skilled nursing benefit period or being discharged home with outpatient or home health agency services.

Managed care plans have significantly reduced approved lengths of stay in skilled nursing or have not approved skilled nursing services in lieu of outpatient or home health agency services.

Residents have increasingly opted to receive home health agency services or At Home Services (provided by Glen Meadows) rather than skilled nursing services.

Access to community-based services such as dementia and memory care services, adult day care services and in-home hospice services have all contributed to the senior remaining in their home and not moving to skilled nursing.

(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.

The most recent Public Use Data available on the MHCC website are for 2014. The Comprehensive Care facilities in Baltimore County during that year operated at 89.41% occupancy when calculated based on the number of licensed beds at the beginning of the year. The data showing this are shown in Table 1 below. It should also be noted that the number of beds licensed at the end of the year was 16 fewer than at the beginning of the year, and the county-wide occupancy was 89.7. In either case, this standard is essentially met.

Table 1
Licensed Beds, Potential Patient Days, Actual Patient Days, and Percent Occupancy
Comprehensive Care Facilities
Baltimore County
2014

	Licensed Beds	Beds x 365	Total Comprehensive Care Patient Days	% Occupancy
Pickersgill Retirement Community	35	12,775	12,189	95.4%
Augsburg Lutheran Home of Maryland	131	47,815	46,309	96.9%
Manor Care Health Services - Rossville	172	62,780	58,714	93.5%
Chapel Hill Nursing Center	63	22,995	21,384	93.0%
ManorCare of Dulaney	139	50,735	40,585	80.0%
Forest Haven Nursing Home	167	60,955	58,910	96.6%
Holly Hill Nursing LLC	75	27,375	23,223	84.8%
Genesis Powerback Rehabilitation - Brightwood Camp	110	40,150	31,052	77.3%
Genesis Catonsville Commons Center	136	49,640	44,035	88.7%
Oakwood Care Center	130	47,450	45,138	95.1%
Little Sisters of the Poor/St.Martin's Home for th	38	13,870	13,221	95.3%
Manor Care Health Services - Ruxton	179	65,335	60,946	93.3%
Manor Care Health Services - Towson	127	46,355	40,731	87.9%
Maryland Masonic Homes	88	32,120	18,298	57.0%
Milford Manor Nursing & Rehabilitation Center	100	36,500	31,616	86.6%
Glen Meadows Retirement Community	31	11,315	11,067	97.8%
Autumn Ridge at North Oaks	37	13,505	9,032	66.9%
Genesis Perring Parkway Center -	110	40,150	36,182	90.1%
Envoy of Pikesville	140	51,100	47,082	92.1%
Presbyterian Home of Maryland	22	8,030	6,280	78.2%
Broadmead	70	25,550	18,299	71.6%
Patapsco Valley Center Genesis Health Care	160	58,400	53,367	91.4%
Ridgeway Manor Nursing & Rehabilitation Center	61	22,265	19,433	87.3%
St. Joseph's Nursing Home	44	16,060	15,944	99.3%
Chestnut Green Health Care Center at Blakehurst	44	16,060	14,144	88.1%
Stella Maris, Inc.	412	150,380	138,459	92.1%
Summit Park Health & Rehabilitation	134	48,910	44,370	90.7%
Genesis Loch Raven Center	113	41,245	36,894	89.5%
Genesis Multi Medical Center	118	43,070	38,363	89.1%
Frederick Villa Nursing Center	125	45,625	41,369	90.7%
Riverview Rehabilitation and Health Center	238	86,870	79,678	91.7%
FutureCare-Old Court	141	51,465	46,987	91.3%
FutureCare Courtland	151	55,115	50,874	92.3%
Genesis Cromwell Center	135	49,275	42,611	86.5%
Genesis Heritage Center	177	64,605	59,139	91.5%

FutureCare - NorthPoint	155	56,575	52,760	93.3%
Edenwald	86	31,390	23,602	75.2%
Charlestown Care Center - Renaissance Gardens	206	75,190	62,658	83.3%
FutureCare-Cherrywood	167	60,955	57,074	93.6%
Genesis Franklin Woods Center	117	42,705	39,226	91.9%
Northwest Hospital Center-Sub Acute Unit	29	10,585	9,720	91.8%
Maria Health Care Center	32	11,680	10,713	91.7%
Mercy Villa Convent	30	10,950	7,461	68.1%
Oak Crest Village Care Center	200	73,000	68,872	94.3%
GBMC Subacute	25	9,125	8,321	91.2%
Manor Care Health Services - Woodbridge Valley	120	43,800	39,939	91.2%
Lorien Mays Chapel	93	33,945	30,324	89.3%
Total	5,413	1,975,745	1,766,595	89.41%

Source: MHCC Public Use Data Base 2014

(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.

See the response to 10.24.08.05A(2), above.

(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.**

GM has no outstanding Level G or higher deficiencies. Tab 5.B includes a letter demonstrating compliance. GM maintains a demonstrated program of quality assurance. Tab 5.A also includes GM'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.

As stated in response to Standard COMAR 10.24.08.05B(1), allowing GM to admit people from the public will improve access in the areas. All of the existing facilities are located to the south and west of GM, with no other facilities located in GM's Zip Code and north. This would allow for a re-distribution of existing beds already in the MHCC's bed inventory. It would result in residents of this section of the county having a choice to go to a high quality facility that is closer to their homes.

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

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

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

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

Not applicable, as this project does not include renovation.

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

(a) Shall participate in the Medicaid Program;

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

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

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

Not applicable, as this project does not include renovation.

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

Health Care Quality and the State Fire Marshall's Office.

Not applicable, as this project does not include renovation.

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.

Please see the response to COMAR 10.24.08.05B(1), which is hereby incorporated into this response.

This project is needed to make GM profitable. Over the past few years GM's health center has experienced a decline in occupancy resulting in a revenue shortfall. As a result, the health center at Glen Meadows Retirement Community has excess capacity to provide services to non-CCRC residents. We do not anticipate being able to fill the excess or empty beds with internal residents due to the following:

Centers for Medicare and Medicaid Services has implemented various initiatives that incentivize (or penalize) acute care providers to provide services to beneficiaries more efficiently. This has resulted in Medicare beneficiaries not obtaining

a 3-day qualifying hospital stay to trigger a skilled nursing benefit period or being discharged home with outpatient or home health agency services.

Managed care plans have significantly reduced approved lengths of stay in skilled nursing or have not approved skilled nursing services in lieu of outpatient or home health agency services.

Residents have increasingly opted to receive home health agency services or At Home Services (provided by GM) rather than skilled nursing services.

It is the goal of GM to reach and maintain financial viability. Obtaining the public beds will allow GM to serve its own residents as well as the local community including residents of other assisted living communities and areas north of GM.

Nursing centers require high fixed staffing and operating costs. As such nursing census can have a significant effect on profitability. Directly related to the healthcare environment noted above, our nursing census was only 71% for 2016 and is 60% year to date in 2017, resulting in an average of 9 and 12 beds respectively not in use each year. During this time period, our independent living census was high and stable, with very few unsold units. As a result, GM's operating loss in 2016 was $700,000. While we have tried to minimize the burden of this loss to present GM residents, prudently we had to increase independent living monthly fees to residents by 6% in 2017. This still results in a budgeted loss. Improving nursing occupancy is essential to GM's financial viability and maintaining the kind of care and resident fees we take pride in providing.

Even just five additional beds occupied even at Medicaid rates of $235 a day for a year would provide $428,000 incremental revenues to GM with very little additional cost incurred. With the additional beds, we would also have the flexibility of taking additional shorter term stays, if appropriate, and still serve all of the present GM residents' needs. Also some residents may then transition to assisted living on our campus, or even independent living.

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.

This project does not involve any construction or renovation. There are no more cost-effective alternatives.

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 stated previously, this project is needed to make GM profitable. Over the past few years GM's health center has experienced a decline in occupancy resulting in a revenue shortfall. As a result, the health center at Glen Meadows Retirement Community has excess capacity to provide services to non-CCRC residents. We do not anticipate being able to fill the excess or empty beds with internal residents due to the following:

Centers for Medicare and Medicaid Services has implemented various initiatives that incentivize (or penalize) acute care providers to provide services to beneficiaries more efficiently. This has resulted in Medicare beneficiaries not obtaining a 3-day qualifying hospital stay to trigger a skilled nursing benefit period or being discharged home with outpatient or home health agency services.

Managed care plans have significantly reduced approved lengths of stay in skilled nursing or have not approved skilled nursing services in lieu of outpatient or home health agency services.

Residents have increasingly opted to receive home health agency services or At Home Services (provided by GM) rather than skilled nursing services.

It is the goal of GM to reach and maintain financial viability. Obtaining the public beds will allow GM to serve its own residents as well as the local community including residents of other assisted living communities and residents from northern areas.

Nursing centers require high fixed staffing and operating costs. As such, nursing census can have a significant effect on profitability. Directly related to the healthcare environment noted above, our nursing census was only 71% for 2016 and is 60% year to date in 2017, resulting in an average of 9 and 12 beds respectively not in use each year. During this time period, our independent living census was high and

stable, with very few unsold units. As a result, GM's operating loss in 2016 was $700,000. While we have tried to minimize the burden of this loss to present GM residents, prudently we had to increase independent living monthly fees to residents by 6% in 2017. This still results in a budgeted loss. Improving nursing occupancy is essential to GM's financial viability and maintaining the kind of care and resident fees we take pride in providing.

Even just five additional beds occupied even at Medicaid rates of $235 a day for a year would provide $428,000 incremental revenues to GM with very little additional cost incurred. With the additional beds, we would also have the flexibility of taking additional shorter term stays if appropriate and still serve all of the present GM residents' needs. Also some residents may then transition to assisted living on our campus, or even independent living.

Tab 6 includes GM's most recent audited financial statement.

Tab 7 includes letters of support. As more are received, GM 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.

Glen Meadows has received no CONs within the past 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.

As shown previously, this project will improve access for residents of the northeast region of Baltimore County. It will also improve the financial performance of GM, which has had financial difficulties. Though, GM does not have Zip Code data for admissions to Comprehensive Care at all facilities, GM does not anticipate that this project will have any material impact on other specific facilities, as the number of projected additional admissions at GM is relatively small. This project will have no impact on costs and charges at GM.

TAB 2

CON TABLE PACKAGE

CON TABLE PACKAGE FOR NURSING HOME (CCFs) APPLICATIONS

Name of Applicant: Glen Meadows Retirement Community

Date of Submission:

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				
First Floor	31	1	15	16	31	First Floor	1	15	16	31
				0	0				0	0
				0	0				0	0
				0	0				0	0
				0	0				0	0
SUBTOTAL Comprehensive Care	31	1	15	16	31	SUBTOTAL	1	15	16	31
ASSISTED LIVING						ASSISTED LIVING				
First Floor	7	5	1	6	7	First Floor	5	1	6	7
Second Floor	34	26	4	30	34	Second Floor	26	4	30	34
TOTAL ASSISTED LIVING	41	31	5	36	41	TOTAL ASSISTED LIVING	31	5	36	41
Other Independent Living	196	196		196	196	Other Independent Living	196		196	196
TOTAL OTHER	196	196	0	196	196	TOTAL OTHER	196	0	196	196
FACILITY TOTAL	268	228	20	248	268	FACILITY TOTAL	228	20	248	268

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
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	0	0	0	0	0

TABLE C. PROJECT BUDGET

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

	CCF Nursing Home	Other Service Areas	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL New Construction	**$0**	**$0**	**$0**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL Renovations	**$0**	**$0**	**$0**
c. Other Capital Costs			
(1) Movable Equipment			$0
(2) Contingency Allowance			$0
(3) Gross interest during construction period			$0
(4) Other - **Purchase of 22 public beds**	$88,000		$88,000
SUBTOTAL Other Capital Costs	***$88,000***	***$0***	**$88,000**
TOTAL CURRENT CAPITAL COSTS	**$88,000**	**$0**	**$88,000**
d. Land Purchased/Donated			
e. Inflation Allowance			
TOTAL CAPITAL COSTS	**$88,000**	**$0**	**$88,000**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c. Legal Fees (CON)	$25,000		$25,000
d. Legal Fees (Other)			$0
e. Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON) - Consultant Fees to manage oversight of CON application	$25,000		$25,000
f. Non-Legal Consultant Fees			
g. Liquidation of Existing Debt			$0
h. Debt Service Reserve Fund			$0
i. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$50,000***	***$0***	**$50,000**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$138,000***	***$0***	***$138,000***
B. Sources of Funds			
1. Cash	**$138,000**		$138,000
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	**$138,000**	**$0**	**$138,000**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0

4.	**Minor Movable Equipment**			$0
5.	**Other** ***(Specify/add rows if needed)***			$0

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

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to 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	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020				
1. ADMISSIONS										
a. Comprehensive Care (public)	0	0	0	37	47	51				
b. Comprehensive Care (CCRC Restricted)	75	84	86	83	79	75				
Total Comprehensive Care	**75**	**84**	**86**	**120**	**126**	**126**	**0**	**0**	**0**	**0**
c. Assisted Living	13	26	30	31	32	32				
d. Other Independent Living	38	36	38	39	40	40				
TOTAL ADMISSIONS	***126***	***146***	***154***	***190***	***198***	***198***				
2. PATIENT DAYS										
a. Comprehensive Care (public)	0	0	0	1,278	2,373	3,294				
b. Comprehensive Care (CCRC Restricted)	10,004	8,046	8,216	7,548	7,472	7,258				
Total Comprehensive Care	**10,004**	**8,046**	**8,216**	**8,826**	**9,844**	**10,552**	**0**	**0**	**0**	**0**
c. Assisted Living	9,154	10,177	9,621	9,800	10,000	11,000				
d. Other Independent Living	67,306	66,940	66,580	67,000	67,500	67,800				
TOTAL PATIENT DAYS	***86,464***	***85,163***	***84,417***	***85,626***	***87,344***	***89,352***				
3. NUMBER OF BEDS										
a. Comprehensive Care (public)	0	0	0	10	10	10				
b. Comprehensive Care (CCRC Restricted)	31	31	31	21	21	21				
Total Comprehensive Care Beds	**31**	**31**	**31**	**31**	**31**	**31**	**0**	**0**	**0**	**0**
c. Assisted Living	48	48	48	48	48	48				
d. Other Independent Living	196	196	196	196	196	196				
TOTAL BEDS	***275***	***275***	***275***	***275***	***275***	***275***	***0***	***0***	***0***	***0***

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to 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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**				
4. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	#DIV/0!	#DIV/0!	#DIV/0!	35.0%	65.0%	90.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. Comprehensive Care (CCRC Restricted)	88.4%	70.9%	72.6%	98.5%	97.5%	94.4%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comprehensive Care Beds	**88.4%**	**70.9%**	**72.6%**	**78.0%**	**87.0%**	**93.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living	52.2%	57.9%	54.9%	55.9%	57.1%	62.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Other Independent Living	94.1%	93.3%	93.1%	93.7%	94.4%	94.5%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**86.1%**	**84.6%**	**84.1%**	**85.3%**	**87.0%**	**88.8%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)										
a. Adult Day Care										
b. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. UTILIZATION PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of proposed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must 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							
1. ADMISSIONS							
a. Comprehensive Care (public)							
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL ADMISSIONS	***0***	***0***	***0***				
2. PATIENT DAYS							
a. Comprehensive Care (public)							
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living							
TOTAL PATIENT DAYS	***0***	***0***	***0***				
3. NUMBER OF BEDS							
a. Comprehensive Care (public)							
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL BEDS	***0***	***0***	***0***	***0***	***0***	***0***	***0***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. Comprehensive Care (public)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. Comprehensive Care (CCRC Restricted)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comprehensive Care Beds	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)							
a. Adult Day Care							
b. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**				
1. REVENUE										
a. Inpatient Services	$ 10,341,474	$ 9,683,027	$ 13,239,773	$ 14,121,058	$ 15,473,774	$ 16,778,046				
b. Outpatient Services	$ 612,403	$ 448,468	$ 354,322	$ 364,951	$ 375,900	$ 387,177				
Gross Patient Service Revenues	***$ 10,953,877***	***$ 10,131,495***	***$ 13,594,095***	***$ 14,486,010***	***$ 15,849,674***	***$ 17,165,222***	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt	$ (14,637)	$ -	$ -							
d. Contractual Allowance	$ (794,571)	$ (1,091,694)	$ (1,169,690)	$ (1,356,521)	$ (1,657,727)	$ (1,925,924)				
e. Charity Care	$ (464,873)	$ (521,945)	$ (525,494)	$ (497,642)	$ (544,416)	$ (673,739)				
Net Patient Services Revenue	***$ 12,227,958***	***$ 11,745,134***	***$ 11,898,911***	***$ 12,631,848***	***$ 13,647,531***	***$ 14,565,560***	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)										
Amortization/Residual Amortization	$ 841,134	$ 821,365	$ 811,674	$ 830,908	$ 850,616	$ 870,811				
Barber/Beauty Commissions	$ 10,954	$ 8,980	$ 10,000	$ 10,300	$ 10,609	$ 10,927				
Other	$ 2,529	$ 30,726	$ 66,130	$ 68,114	$ 70,157	$ 72,262				
NET OPERATING REVENUE	***$ 13,082,574***	***$ 12,606,205***	***$ 12,786,716***	***$ 13,541,169***	***$ 14,578,914***	***$ 15,519,560***	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 5,228,653	$ 5,440,257	$ 5,599,990	$ 5,795,904	$ 5,940,802	$ 6,089,322				
b. Contractual Services	$ 1,985,856	$ 1,424,459	$ 1,154,870	$ 1,183,742	$ 1,213,336	$ 1,243,669				
c. Interest on Current Debt	**$ 276,891**	**$ 318,292**	**$ 426,305**	**$ 527,589**	**$ 499,081**	**$ 469,368**				
d. Interest on Project Debt										
e. Current Depreciation	$ 1,902,583	$ 1,950,263	$ 1,931,197	$ 2,006,197	$ 2,081,197	$ 2,143,633				
f. Project Depreciation										
g. Current Amortization	***$ 16,229***	***$ 16,229***	***$ 16,229***	***$ 16,229***	***$ 16,229***	***$ 16,229***				
h. Project Amortization										
i. Supplies	$ 324,995	$ 383,924	$ 314,200	$ 322,055	$ 330,106	$ 338,359				
j. Other Expenses (Specify/add rows if needed)										
Management Fee	$ 1,175,220	$ 1,240,548	$ 1,134,392	$ 1,162,752	$ 1,191,821	$ 1,221,616				
Utilities	$ 749,663	$ 790,630	$ 738,404	$ 756,864	$ 775,786	$ 795,180				
Maintenance & Repair	$ 345,967	$ 190,562	$ 248,500	$ 254,713	$ 261,080	$ 267,607				
Real Estate Taxes	$ 340,913	$ 336,345	$ 336,000	$ 344,400	$ 353,010	$ 361,835				
Food	$ 682,341	$ 672,832	$ 660,459	$ 676,970	$ 693,894	$ 711,242				

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**				
Pharmacy & Medical Ancillaries	$ 161,471	$ 170,769	$ 184,189	$ 188,794	$ 193,513	$ 198,351				
Other	$ 731,721	$ 562,470	$ 643,042	$ 846,374	$ 1,118,444	$ 1,146,405				
TOTAL OPERATING EXPENSES	**$ 13,922,502**	**$ 13,497,581**	**$ 13,387,777**	**$ 14,082,583**	**$ 14,668,299**	**$ 15,002,817**	**$ -**	**$ -**	**$ -**	**$ -**

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	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**				
3. INCOME										
a. Income From Operation	$ (839,928)	$ (891,376)	$ (601,061)	$ (541,413)	$ (89,385)	$ 516,743	$ -	$ -	$ -	$ -
b. Non-Operating Income	$ (115,055)	$ 234,813	$ 170,000	$ 174,600	$ 179,328	$ 184,188				
SUBTOTAL	***$ (954,983)***	***$ (656,563)***	***$ (431,061)***	***$ (366,813)***	***$ 89,943***	***$ 700,931***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ (954,983)***	***$ (656,563)***	***$ (431,061)***	***$ (366,813)***	***$ 89,943***	***$ 700,931***	***$ -***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	13.5%	12.0%	11.7%	13.9%	16.8%	17.9%				
2) Medicaid	7.0%	5.6%	5.8%	5.4%	5.2%	6.1%				
3) Blue Cross										
4) Commercial Insurance	0.7%	1.6%	2.0%	2.0%	2.1%	1.8%				
5) Self-pay	79.6%	80.5%	80.3%	76.9%	74.2%	72.5%				
6) Other	-0.80%	0.4%	0.1%	1.8%	1.7%	1.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days										
1) Medicare	2.3%	2.6%	2.5%	3.2%	4.1%	4.5%				
2) Medicaid	4.8%	3.6%	3.8%	3.6%	3.5%	4.2%				
3) Blue Cross										
4) Commercial Insurance	0.5%	0.1%	1.1%	1.0%	1.3%	1.2%				
5) Self-pay	92.3%	93.7%	92.6%	92.3%	91.0%	90.1%				
6) Other										
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

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

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

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY							
1. REVENUE							
a. Inpatient Services							
b. Outpatient Services							
Gross Patient Service Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt							
d. Contractual Allowance							
e. Charity Care							
Net Patient Services Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. EXPENSES							
a. Salaries & Wages (including benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies							
j. Other Expenses (Specify)							
TOTAL OPERATING EXPENSES	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. INCOME							
a. Income From Operation	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Non-Operating Income							
SUBTOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -
c. Income Taxes							
NET INCOME (LOSS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

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*	**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)*											
General & Administrative	5.2	$64,941	$335,696			$0			$0	5.2	$361,508
Nursing Administration	2.6	$87,025	$230,533			$0			$0	2.6	$248,259
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	7.8	$151,966	$566,229	0.0	$0	$0	0.0	$0	$0	7.8	$609,767
Direct Care Staff *(List general categories, add rows if needed)*											
Assisted Living Aide	5.1	$37,829	$193,909			$0			$0	5.1	$208,819
Assisted Living Assistant	1.4	$37,254	$53,213			$0			$0	1.4	$57,305
Assisted Living LPN	4.4	$59,261	$259,012			$0			$0	4.4	$278,928
Health Center RN	4.5	$87,290	$391,505			$0			$0	4.5	$421,608
Health Center LPN	1.6	$56,128	$88,077			$0			$0	1.6	$94,849
Health Center CNA	9.1	$38,167	$347,592	1.5	$39,121	$58,681			$0	10.6	$434,468
At Home Services	8.2	$43,262	$354,648			$0			$0	8.2	$381,917
Total Direct Care	34.3	$359,191	$1,687,956	1.5	$39,121	$58,681	0.0	$0	**$0**	35.8	$1,877,894
Support Staff *(List general categories, add rows if needed)*											
Maintenance	8.6	$59,361	$508,164			$0			$0	25.7	$547,237
Security	4.8	$39,011	$187,833			$0			$0	14.4	$202,276
Transportation	1.3	$31,512	$40,541			$0			$0	3.9	$43,658
Housekeeping	10.6	$31,448	$333,245			$0			$0	31.8	$358,868
Dietary	26.2	$35,602	$932,858			$0			$0	78.6	$1,004,586
Resident Activities	4.1	$36,569	$149,176			$0			$0	12.2	$160,646
Fitness	0.6	$41,803	$26,207			$0			$0	1.9	$28,222

TABLE H. WORKFORCE INFORMATION

Chaplain	0.8	$58,669	$47,048			$0			$0	2.4	$50,666
Social Services	1.0	$63,024	$63,206			$0			$0	3.0	$68,066
			$0								
			$0								
			$0			$0			$0	0.0	$0
Total Support	58.0	$396,998	$2,288,278	0.0	$0	$0	0.0	$0	$0	173.9	$2,464,225
REGULAR EMPLOYEES TOTAL	***100.1***	***$908,156***	***$4,542,463***	***1.5***	***$39,121***	***$58,681***	***0.0***	***$0***	***$0***	***217.5***	***$4,951,886***

TABLE H. WORKFORCE INFORMATION

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)*:										
Percentage of Wages based on budget projections			$1,057,527			$13,662					$1,137,436
TOTAL COST	***100.1***		***$5,599,990***	***1.5***		***$72,343***	***0.0***		***$0***		***$6,089,322***

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	8	8	8	24		8	0	8	16
L. P. N. s	8	0	0	8		0	8	0	8
Aides	0	0	0	0		0	0	0	0
C. N. A.s	22.5	22.5	22.5	52.5		22.5	22.5	22.5	52.5
Medicine Aides	0	0	0	0		0	0	0	0
Total	38.5	23	23	84.5		30.5	23	23	76.5
Licensed Beds at Project Completion				31		**Licensed Beds at Project Completion**			31
Hours of Bedside Care per Licensed Bed per Day				2.73		**Hours of Bedside Care per Licensed Bed Per Day**			2.47

	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%	0	0	0	0		0	0	0	0
Total Including 50% of Ward Clerks Time	0	0	0	0		0	0	0	0
Total Hours of Bedside Care per Licensed Bed Per Day				2.73		**Total Hours of Bedside Care per Licensed Bed Per Day**			2.47

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		
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE K. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COST

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

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

BUILDING COSTS		
Normal Building Costs		
Subtotal included in Marshall Valuation Costs	$0	
Canopy		
Premium for Labor Shortages on Eastern Shore Projects		
LEED Silver Premium		
Siesmic Costs		
Pneumatic Tube System		
Transvac System		
Signs		
Premium for Minority Business Enterprise Requirement		
Subtotal Building Costs excluded from Marshall Valuation Costs	$0	
TOTAL Building Costs included and excluded from Marshall Valuation Service*	$0	#REF!
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	$0
PERMIT COSTS		
Normal Permit Costs		
Subtotal included in Marshall Valuation Costs	$0	
Jurisdictional Hook-up Fees		
Impact Fees		
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*		$0

TAB 3

DISCHARGE MATERIALS

PRESBYTERIAN
SENIOR LIVING

Folder Name: Administration
Title: Discharge Planning Policy
Created Date: 01/15/2004
Last Approved: 8/16/2016 8:47:58 PM

Discharge Planning Policy

Policy: Each Presbyterian Senior Living facility has a coordinated discharge planning process to ensure that every resident has continuity of care both during this stay and after discharge from the facility. A Discharge Plan is developed as part of the Comprehensive Assessment and Interdisciplinary Care Planning Process for each resident within seven days of admission. Discharge planning is an ongoing process.

Objective: To provide continuity of care for residents during and after a stay in a long term care facility.

Guidelines:

1. The Discharge Plan is developed by Social Services with input from the attending physician, the interdisciplinary team, the resident, and the residents family or legal representative, if indicated.

2. The Discharge Plan contains information on resident and family goals, community resources, financial resources, availability of in-home support.

3. The Discharge Plan is considered part of the Interdisciplinary Plan of Care.

4. The Discharge Plan is reviewed quarterly, is revised as needed, and is communicated to resident and/or responsible person.

5. The Discharge Plan is based on the comprehensive assessment of the resident and addresses objectives to meet expectations for discharge.

6. Discharge Instructions are created to assure continuity of care after discharge.

7. Discharge Instructions are developed to assist the resident in adjusting to his/her new or former living environment.

8. Discharge Instructions will describe the resident's and family's preferences for care, how the resident and family will access and pay for these services and how care will be coordinated if multiple caregivers are a part of the continuum of care.

9. Discharge Instructions identify specific resident needs after discharge and describes resident and/or caregiver education to prepare for discharge.

PRESBYTERIAN
SENIOR LIVING

Folder Name: Administration

Title: Discharge-Transfer Process

Created Date: 01/15/2004

Last Approved: 8/16/2016 8:48:14 PM

Transfer and Discharge Process

Policy: Residents have the right to remain in the facility and not be transferred or discharged unless: necessary to the residents' welfare; health has improved sufficiently to not require facility services; safety and/or health of other persons in the facility is endangered; non-payment of charges exists following reasonable and appropriate notice or the facility ceases to operate.

Residents have the right to safe and orderly transfer and advance notice. The notice to residents and/or responsible party must be made at least 30 days in advance of the transfer or discharge except in cases where the safety and/or health of individuals in the facility is endangered; or residents' health improves sufficiently to allow a more immediate transfer or discharge to a lower level of care; or the more immediate transfer or discharge is necessitated by the residents' urgent medical need.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as practical.

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfers or discharges from the facility. Before residents are transferred for hospitalization, the facility must provide written information to residents and/or responsible party, if appropriate, concerning the provisions of the state plan under Title XIX regarding the period (if any) during which residents will be permitted to return and resume residence in the facility; and at the time of transfer of residents to a hospital, the facility must provide written notice to residents and/or responsible party, if appropriate, of the duration of any period regarding bed holding policy.

Residents and/or responsible party, when appropriate have the right to hold a bed at a fee established by the facility and communicated in advance in writing. Residents and/or responsible party, when appropriate, not wishing to pay a fee to hold their bed when in the hospital may return to the first appropriate semiprivate bed available.

Objective: The facility will coordinate orderly transfer or discharge of residents and their personal belongings to their own environment or to another health care facility. There will be a coordinated transfer of information, services and care to the receiving facility or caregiver.

Guidelines:

Transfer

1. Upon request to transfer resident care to a different provider or discharge, a physician order will be obtained prior to transfer or discharge. The resident will be assessed for meeting established transfer criteria.
2. Residents being transferred from the Medicare distinct unit to any other location in the facility will be discharged and readmitted. The chart will remain active and a discharge summary is not required.
3. The organization shall document notification of the resident in a timely fashion when he/she will be transferred or discharged for medical reasons or for the welfare of the other residents.
4. The resident and/or responsible party, when appropriate, and physician will participate in the transfer process, including discussion of alternatives to transfer.
5. The receiving facility, family member, unit, clinician or clinical service will be contacted to confirm acceptance of resident.
6. Referrals for additional services may be made to internal or external sources either by formal affiliation or informal arrangements by professional contacts.
7. The following are criteria for transfer to other organizations:
    a. The transfer is necessary to meet resident's welfare and the resident's welfare cannot be met in the facility.
    b. Health has improved sufficiently so the resident no longer needs services provided by the facility.
    c. The safety of individuals in the facility is endangered.
    d. The health of individuals in facility would otherwise be endangered.
    e. The resident has failed after reasonable and appropriate notice to pay for (or have paid under Title XVIII or Title XIX on the resident's behalf) a stay at the facility.
    f. The facility ceases to operate.
    g. Emergency discharge due to medical necessity.
    h. Resident leaves against medical advice (AMA). Note: The facility shall attempt to have an AMA form signed by the resident and/or responsible party, when appropriate.
8. The organization shall obtain consent of the resident and/or responsible party, when appropriate, to release information to the receiving agency.
9. When the decision to transfer or refer to the resident has been finalized, the following process shall occur:

a. The nurse or social worker will contact the receiving facility to finalize plans for resident acceptance including date, time and responsibility of resident care until transfer.

b. The nurse or social worker will contact the resident and/or responsible party, when appropriate, and physician to inform them that appropriate arrangements have been made including time and date of transfer or referral.

c. The organization shall prepare and orient the resident to provide for a safe, orderly discharge, allowing the resident to understand the reason(s) for the move.

10. The nurse will complete the Transfer Form with applicable information and send to receiving facility.

11. The original Transfer Form will be filed in the resident's medical record and will identify the reason for the transfer (see attached form).

12. Responsibility for the resident will remain with this organization until such time that the transfer process is complete and receiving entity has agreed to accept the resident.

Discharge

The discharge planning process begins during the preadmission process and is a component of the admission assessment. the process may involve the following individuals:

The resident and/or responsible party, when appropriate.

The physician or other licensed independent practitioner responsible for the resident.

Appropriate interdisciplinary staff members participating in care.

TAB 4

WHOLE BUILDING DESIGN GUIDE

WBDG a program of the National Institute of Building Sciences
WHOLE BUILDING DESIGN GUIDE
(/)

SEARCH WBDG

BUILDING TYPES

Unaccompanied Personnel Housing (Barracks) (/building-types/unaccompanied-personnel-housing-barracks-1)

Warehouse (/building-types/warehouse)

NURSING HOME

(HTTPS://WWW.ADDTOANY.COM/SHARE#URL=HTTP%3A%2F%2FWWW.WBDG.ORG%2FBUILDING-TYPES%2FHEALTH-CARE-FACILITIES%2FNURSING-HOME&TITLE=NURSING%20HOME)

by Robert F. Carr
NIKA Technologies, Inc. (http://www.nikatechnologies.com/) for VA Office of Construction & Facility Management (CFM) (http://www.cfm.va.gov/)
Revised by the WBDG Health Care Subcommittee
Updated: 04-21-2011

OVERVIEW

Nursing homes serve patients requiring preventive, therapeutic, and rehabilitative nursing care services for non-acute, long-term conditions. Specialized clinical and diagnostic services are obtained outside the nursing home. Most residents are frail and aged, but not bedridden, although often using canes, walkers, or wheelchairs. Stays are relatively long, the majority for life. Nursing homes also care for a smaller percentage of convalescent patients of all ages. These patients are in long-term recovery from acute illnesses, but no longer require hospitalization.

WITHIN THIS PAGE

Nursing homes, or sections of them, are often classified into intermediate and skilled nursing units, definitions related to Medicare/Medicaid standards. Intermediate-care facilities have just enough nursing to qualify for Medicaid; skilled nursing facilities meet the more demanding medical standards to qualify for Medicare as well as Medicaid support. The cognitively impaired are frequently housed separately in Alzheimer Related Dementia (ASD) units. See Alzheimer's Foundation of America Excellence in Care Program (http://www.excellenceincare.org/)

Nursing homes present special design challenges in that for most residents the nursing home is not just a facility, but indeed their home. The reality is that in most cases the residents will live there for the rest of their lives and, moreover, rarely leave the premises at all. The nursing home

becomes their entire world in a sense. The challenge is to design a nursing home that is sensitive and responsive to long-term human needs and well-being (/design-objectives/productive/promote-health-well-being), both physical and emotional (/resources/psychosocial-value-space).

BUILDING ATTRIBUTES

A nursing home operates primarily in a patient-care mode rather than a medical mode. Consequently, its more important attributes are those focusing on the general well-being of its residents rather than high-tech considerations. The principal attributes of a well designed nursing home are:

Floor Plan of Missouri Veterans Home-St. James, Missouri
Architect: Kennedy Association Inc.
View enlarged plan (/images/media_img.php?m=nursing_1lg.jpg&w=544&h=429)

HOMELIKE AND THERAPEUTIC ENVIRONMENT

Inherent in any institutional stay is the impact of environment on recovery, and the long-term stays typical of nursing home residents greatly increase this impact. The architect and interior designer must have a thorough understanding of the nursing home's mission and its patient profile. It is especially important that the design address aging and its accompanying physical and mental disabilities, including loss of visual acuity. To achieve the appropriate nursing home environment every effort should be made to:

- Give spaces a homelike, rather than institutional, size and scale with natural light (/resources/daylighting) and views of the outdoors
- Create a warm reassuring environment by using a variety of familiar, non-reflective finishes and cheerful, varied colors and textures, keeping in mind that some colors are inappropriate and can disorient or agitate impaired residents
- Provide each resident a variety of spatial experiences, including access to a garden and the outdoors in general
- Promote traditional residential qualities of privacy, choice, control, and personalization of one's immediate surroundings
- Alleviate possible disorientation of residents by providing differences between "residential neighborhoods" of the nursing home, and by use of clocks, calendars, and other "reminders"
- Encourage resident autonomy by making their spaces easy to find, identify, and use
- Provide higher lighting (/resources/energy-efficient-lighting) levels than typical for residential occupancies

EFFICIENCY AND COST-EFFECTIVENESS (/DESIGN-OBJECTIVES/COST-EFFECTIVE)

The nursing home design should:

- Promote staff efficiency by minimizing distance of necessary travel between frequently used spaces
- Allow easy visual supervision of patients by minimal staff
- Make efficient use of space (/space-types) by locating support spaces so they may be shared by adjacent functional areas, and by making prudent use of multi- purpose spaces

CLEANLINESS AND SANITATION

Western New York State Veterans Home Batavia, NY, Kideny Architects

An odor-free environment is a very high priority in nursing homes, since many residents are occasionally incontinent, and the pervasive odors can give an impression of uncleanliness and poor operation to family and visitors. In addition to operational practices and careful choice of furniture, facility design can help odor control by:

- Adequate and highly visible toilet rooms in key locations near spaces where residents congregate
- The use of appropriate, durable finishes for each space used by residents
- Proper detailing of such features as doorframes, casework, and finish transitions to avoid dirt-catching and hard-to-clean crevices and joints
- Adequate and appropriately located housekeeping spaces
- Effective ventilation, which may need to exceed nominal design levels
- Incorporating O&M practices (/resources/sustainable-om-practices) that stress indoor environmental quality (IEQ (/design-objectives/sustainable/enhance-indoor-environmental-quality))

ATTENTION TO WAY-FINDING

A consistent and well thought out system of way-finding helps to maintain the residents' dignity and avoid their disorientation. It should:

- Use multiple cues from building elements, colors, texture, pattern, and artwork, as well as signage, to help residents understand where they are, what their destination is, and how to get there and back.

- Identify frequently used destination spaces by architectural features and landmarks which can be seen from a distance, as well as symbols, signage, art, and elements such as fish tanks, birdcages, or greenery
- Avoid prominent locations and high visibility of doors to spaces which patients should not enter
- Use simple lettering and clear contrasts in signage (See VA Signage Manual (/ffc/va/design-guides-pg-18-12/va-signage))
- Clearly identify only those rooms that residents frequent

ACCESSIBILITY (/DESIGN-OBJECTIVES/ACCESSIBLE)

Many residents may be ambulatory to varying degrees, but will require the assistance of canes, crutches, walkers, or wheelchairs. To accommodate these residents, all spaces used by them, both inside and out, should:

- Comply with the requirements of the Americans with Disabilities (ADA (http://www.usdoj.gov/crt/ada/adahom1.htm)) and, if federally funded or owned, the GSA's ABA Accessibility Standards (http://www.access-board.gov/guidelines-and-standards/buildings-and-sites/about-the-aba-standards/aba-standards)
- Be designed so that all spaces, furnishings, and equipment, including storage units and operable windows, are easily usable by residents in wheelchairs
- Be equipped with grab bars in all appropriate locations
- Be free of tripping hazards
- Be located on one floor if feasible, preferably at grade. If residents' bedrooms must be located on more than one floor, then dining space must be apportioned among those floors, not centralized

SECURITY AND SAFETY (/DESIGN-OBJECTIVES/AESTHETICS/ENGAGE-INTEGRATED-DESIGN-PROCESS)

Design to address security and safety concerns of nursing homes includes:

- Use of non-reflective and non-slip floors to avoid falls
- Control of access to hazardous spaces
- Control of exits to avoid residents leaving and becoming lost or injured
- Provision of secure spaces to safeguard facility supplies and personal property of residents and staff

AESTHETICS (/DESIGN-OBJECTIVES/AESTHETICS)

Aesthetics is closely related to creating a therapeutic homelike environment. It is also a major factor in a nursing home's public image and is thus an important marketing tool for both residents' families and staff. Aesthetic considerations include:

- Increased use of natural light (/resources/daylighting), natural materials, and textures
- Use of artwork
- Attention to proportions, color, scale, and detail
- Bright, open, generously scaled public and congregate spaces
- Homelike and intimate scale in resident rooms and offices
- Appropriate residential exterior appearance, not hospital-like
- Exterior compatibility with surroundings

SUSTAINABILITY (/DESIGN-OBJECTIVES/SUSTAINABLE)

Nursing Home facilities are public buildings that may have a significant impact on the environment and economy of the surrounding community. As facilities built for "caring", it is appropriate that this caring approach extend to the larger world as well, and that they be built and operated "sustainably".

Section 1.2 of VA's HVAC Design Manual is a good example of health care facility energy conservation standards that meet EPAct 2005 (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:h6enr.txt.pdf) and Executive Order 13693 (/ffc/fed/executive-orders/eo-13693) requirements. The Energy Independence and Security Act of 2007 (EISA) (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6enr.txt.pdf) provides additional requirements for energy conservation. Also see LEED's (Leadership in Energy and Environmental Design) USGBC LEED for Healthcare (http://www.usgbc.org/DisplayPage.aspx?CMSPageID=1765).

RELATED ISSUES

The HIPAA (http://www.hipaa.org) (Health Insurance Portability and Accessibility Act of 1996) regulations address security and privacy of "protected health information" (PHI). These regulations put emphasis on acoustic and visual privacy, and may affect location and layout of workstations that handle medical records and other patient information, paper and electronic, as well as patient accommodations."

EMERGING ISSUES

There is a growing recognition of the need for dementia day care. This can often be effectively

provided within or adjoining an inpatient nursing facility.

There is a need for better non-medical residential facilities for the frail but independent elderly.

Managed care programs for the aged are being developed to prevent, or at least postpone, institutionalization.

RELEVANT CODES AND STANDARDS

Like other buildings, nursing homes must follow the local and/or state general building codes. However, federal facilities on federal land generally need not comply with state and local codes, but follow federal regulations. To be licensed by the state, design must comply with the individual state licensing regulations. Many states adopt the *AIA Guidelines for Design and Construction of Hospitals and Health Care Facilities (http://www.aia.org/aah_gd_hospcons)*, listed below as a resource, and thus that volume often has regulatory status.

State and local building codes are based on the model International Building Code (IBC (http://codes.iccsafe.org/app/book/toc/2015/2015%20San%20Antonio/2015%20IBC%20HTML/)). Federal agencies are usually in compliance with the IBC except NFPA 101 (Life Safety Code), NFPA 70 (National Electric Code), and Architectural Barriers Act Accessibility Guidelines (ABAAG) or GSA's ABA Accessibility Standards takes precedence.

To care for residents who are reimbursed under Medicare or Medicaid, facilities must also meet federal standards, and to be accredited, they must meet standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO (http://www.jcaho.org/)). Generally, the federal government and JCAHO refer to the National Fire Protection Association (NFPA (http://www.nfpa.com/)) model fire codes, including Standards for Health Care Facilities (NFPA 99) and the Life Safety Code (NFPA 101).

Library, Missouri Veterans Home, St. James, MO, Kennedy Assoc., Inc.

The American with Disabilities Act (ADA (http://www.ada.gov/)) applies to all public facilities and greatly the building design with its general and specific accessibility requirements. The Architectural Barriers Act Accessibility Guidelines (ABAAG (/ccb/browse_doc.php?d=1351))

or GSA's ABA Accessibility Standards (http://www.access-board.gov/guidelines-and-standards/buildings-and-sites/about-the-aba-standards/aba-standards) apply to federal and federally funded facilities. The technical requirements do not differ greatly from the ADA requirements. See WBDG Accessible (/design-objectives/accessible).

Federal agencies that build and operate, or fund, nursing homes have developed detailed standards for the programming, design, and construction of their facilities. Many of these standards are applicable to the design of non-governmental facilities as well. Among them are:

- Department of Veterans Affairs (VA), Office of Construction & Facilities Management Technical Information Library (http://www.cfm.va.gov/TIL/) contains many guides and standards, including:
    - Design Manuals of technical requirements, equipment lists, master specifications, room finishes, space planning criteria, and standard details.

MAJOR RESOURCES

WBDG

FEDERAL MANDATE

Executive Order 13693, "Planning for Federal Sustainability in the Next Decade" (/ffc/fed/executive-orders/eo-13693)

PRODUCTS AND SYSTEMS

Building Envelope Design Guide (/systems-specifications/building-envelope-design-guide)

WEBSITES

See WBDG Health Care Facilities (/building-types/health-care-facilities) for generic health care facilities websites

PUBLICATIONS

- *Contemporary Environments for People with Dementia* by Cohen and Day. Baltimore, MD: Johns Hopkins Press, 1993.
- *Design Details for Health: Making the Most of Design's Healing Potential, 2nd Edition (http://www.tkqlhce.com/click-2191068-10438326?url=http%3A%2F%2Fwww.wiley.com%2Fremtitle.cgi%3Fisbn%3D0470524715&cjsku=0470524715)* by Cynthia A. Leibrock and Debra Harris. New York: John Wiley & Sons, Inc., 2011.-Innovative design solutions in key areas such as lighting, acoustics, color, and finishes
- *Design for Dementia* by Margaret Calkins. Owings Mills, MD: National Health Publishing, 1988.
- *Design of Long-Term Care Facilities* by Aranyi and Goldman. New York: Van Nostrand Reinhold, 1980.
- *Design That Cares: Planning Health Facilities for Patients and Visitors, 2nd Edition (http://www.kqzyfj.com/click-2191068-10438326?url=http%3A%2F%2Fwww.wiley.com%*

2Fremtitle.cgi%3Fisbn%3D0787957399&cjsku=0787957399) by Janet Carpman, Myron Grant, and Deborah Simmons. New York: John Wiley & Sons, Inc., 2001.

- *Designing for Alzheimer's Disease: Strategies for Creating Better Care Environments (http://www.jdoqocy.com/click-2191068-10438326?url=http%3A%2F%2Fwww.wiley.com%2Fremtitle.cgi%3Fisbn%3D0471139203&cjsku=0471139203)* by Elizabeth Brawley. New York: John Wiley & Sons, Inc., 1997.
- *Designing the Open Nursing Home* by J.A. Koncelik. Stroudsburg, Pa.: Dowden, Hutchinson, and Ross, 1976.
- *Hospital Related Facilities for the Elderly* by Alicen Hall. Lubbock, Tex.: Texas A&M University, 1997.
- *Nursing Home Design* by Benjamin Schwarz. New York: Garland Publishing, 1996.
- *Nursing Home Renovation Designed for Reform* by Lorraine Hiatt. Boston: Butterworth Architecture, 1991.
- *Sound & Vibration: Design Guidelines for Health Care Facilities (http://speechprivacy.org/joomla//index.php?option=com_content&task=view&id=33&Itemid=43)* by the Acoustics Research Council. 2010.
- See WBDG Health Care Facilities (/building-types/health-care-facilities) for generic health care facilities publications

TAB 5

QUALITY MATERIALS

PRESBYTERIAN
SENIOR LIVING

Folder Name: QAPI

Title: QAPI policy

Created Date: 4/28/2014

Last Approved: 4/3/2015 2:05:40 PM

Quality Assurance and Process Improvement - QAPI

Mission: The mission of Presbyterian Senior Living is to offer Christian understanding, compassion and a sense of belonging to promote wholeness of body, mind and spirit.

Vision: To continue to offer a full range of services in a way that reflects the love of Christ by:

- Providing the highest quality of service to persons served and clients.
- Constantly seeking to improve the environment where employees and volunteers can express their calling to serve others.
- Leading the field of retirement and supportive services in the application of innovation and state of the art technology to meet the needs of current and future persons served.
- Being involved with the diverse communities we serve

Purpose: Presbyterian Senior Living endeavors to provide consistent, dynamic, caring services to its customers across the continuum. Organizational Governance empowers staff to establish quality assurance/quality improvement programs in a systematic, coordinated and continuous approach that supports the vision of providing the highest quality of service to persons served, focusing on the processes and mechanisms that strive for improved performance and outcomes. This process is an ongoing dynamic process supports the mission of promoting the wholeness of body, mind and spirit. Analysis should include effectiveness of services offered, the efficiency of services offered, access of services to stakeholders and persons served and satisfaction feedback from persons served and other stakeholders.

Guiding Principles:

- Provide service excellence thereby enhancing the quality of life of the person served through a program that focuses on the person served.
- Improve person served satisfaction to achieve the highest possible utilization of services and establish community support.

- Includes all employees, all departments and all services provided.
- Focuses on systems and processes rather than individuals. The emphasis is on identifying system gaps rather than focusing on individuals utilizing fierce conversation principles.
- Makes decisions based on data which includes input and experience of caregivers, persons served, healthcare practitioners, families, and other stakeholders.
- A culture that encourages rather than punishes employees who identify errors or system breakdowns.
- Meet regulatory, third party payer, and accrediting agency standards

Scope:

- The Executive Director/Campus Administrator has responsibility and accountability for the development and implementation of the QAPI program for the overall campus. The Nursing Home Administrator has responsibility for over sight of the Health Center.
- ***QAPI*** is a continuous daily process that involves all stakeholders. The sub-committees evaluate trends with quarterly summaries. An analysis will be done at least annually to evaluate the ***QAPI*** process. This should include effectiveness of services, efficiency of services, service access and satisfaction feedback from persons served and other stakeholders.
- Community ***QAPI*** stake holders shall determine the services to be monitored evaluated and improved.
- Written analysis of all critical incidents is provided to or conducted by the leadership that addresses: Necessary education and training of personnel, prevention of recurrence, Internal and external reporting requirements.
- The appropriateness and quality of service delivery provided to persons served will be objectively measured and systematically evaluated.
- The ***QAPI*** Committee shall make recommendations toward continuous improvement of care and service, develop and apply indicators and thresholds for evaluation, ensure that appropriate actions are implemented to improve services, and monitor processes for effectiveness. The committee will utilize established thresholds/ benchmarks including the ***PSL Measures of Success*** to identify areas where improvement may be needed.

Structure:

- The Community ***QAPI*** Committee meets at least quarterly.
- Activities include developing best practices, reviewing established thresholds, sharing data and reporting on performance improvement processes.
- The following required sub-committees meet on a monthly basis:

It is the responsibility of the Chair of each sub-committee to ensure participants are prepared to discuss identified issues. The committee chair will also be responsible for inviting ad hoc committee participants.

Finance Committee

Reviews and takes action on the following items:

Operating margin, Controllable change in net assets, Reimbursement rates, Census and payor mix across all levels of care, expenses, missed opportunities (Medicare RUGS, managed care levels, Medicaid, Part B), other related financial matters.

Resources:

- Benchmarking
- Measures of Success
- Community Performance Report
- MA CMI impact report

Participants:

- Executive Director/Campus Administrator- Chair
- Business Office Manager
- Financial Advisor
- Assistant Executive Director and/or Nursing Home Administrator
- Independent Living Director
- AL/PC Administrator/Manager
- Director of Nursing
- RNAC
- DES/Maintenance Director
- Dining Services Director/Manager
- Persons served

Quality committee:

Reviews and takes action on the following:

Infection Rate, medication errors, licensure and certification survey results (HC/PC/AL/Home Care), pharmacy, DOH/DPW reporting, PB 22 reports,. QM's, Falls, Wounds, Weight changes, Hospital readmissions within 30 days of admission, psychotropic medications, pain, resident incidents, customer satisfaction survey results and other related quality items.

Resources:

- Rehab outcomes
- DON report

- Weekly At Risk meeting
- My InnerView
- QI/QM Report
- Survey results (DOH/DPW/HC)
- COMS Daylight IQ reports
- Score cards
- Compliance audits
- Peer review surveys
- Medical Director Report
- Customer Satisfaction Survey

Participants:

- Director of Nursing/Designee - Chair
- AL/PC Administrator/Manager
- Independent Living representative
- Rehab Manager
- Executive Director/Campus Administrator
- Assistant Executive Director and/or Nursing Home Administrator
- ADON/Infection control nurse
- Dietician
- Director of Community Life
- Social Worker
- RNAC
- Environmental Services Representative
- Dining Services Director/Manager

People Committee:

Reviews and takes action on the following:

Turnover, employee survey, Retention rate, OSHA reportable, Workmen's comp., Staff educations, HPPD, Overtime, Open positions/staff vacancies, employee incident trending, visitor incident trending, Life Safety Survey Results

Resources:

- DART rate
- SOS/Monarch reports
- Monthly turnover report
- Vacancy tracker
- Enterprise reports
- Incident reports
- Employee surveys
- UltiPro reports
- Relias Learning Reports

Participants:

- Human Resource Manager—Chair
- Executive Director/Campus Administrator
- Assistant Executive Director and/or Nursing Home Administrator
- Director of Nursing
- Director of Environmental Services /Maintenance Director
- Dining Services Director/Manager
- Staff Development/ADON
- Independent Living Manager/Director
- AL/PC Administrator/Manager

Ad Hoc:

- Scheduler
- Payroll coordinator
- HR Assistant

Service Committee:

Reviews and takes action on the following:

Census, willing to recommend, environment, grievance, resident council/association, Person centered care initiatives (activities, dining, nursing, housekeeping, maintenance), Resident Assistive Technology

Resources:

- Resident satisfaction surveys
- Annual
- Post discharge
- Dining
- Therapy
- Grievance logs
- Activity calendar
- Resident council/association meeting minutes
- LINK Line calls
- Lifestyle Review
- Sara system reports
- Score cards

Participants:

- Social Worker – Co-Chair
- Director of Community – Co-Chair
- Marketing
- Director of Environmental Services /Maintenance Director
- Dining Services Director/Manager
- Staff members from various levels of living
- Masterpiece Living champion

- Masterpiece Living coordinator
- Resident leadership
- Executive Director/Campus Administrator
- Assistant Executive Director and/or Nursing Home Administrator

- All records and activities of ***QAPI*** are confidential. Program overview and areas for improvement may be shared with stake holders for engagement in the improvement process. For states requiring minutes of committee activity a report will be submitted.
- Each facility shall submit a summary of ***QAPI*** activities to Corporate QAPI Committee on a Quarterly basis. Significant Activities are reported to the respective Boards of Directors.
- Community ***QAPI*** committee membership should include interested stakeholders and others as required by regulations and accrediting agencies.
- Approved forms and formats must be utilized for reporting purposes.
- Minutes should include trends, improvement plans, actions, measurement of outcomes.
- Minutes should contain only de-identified information.

Corporate *QAPI* Committee

Purpose:

Facility staff come together to share best practices, establish thresholds for evaluation, identify organizational trends and review and communicate comparative performance measurement data to enhance the lives of persons served. This committee will be utilized to brainstorm issues and identify opportunities for growth and barriers to change.

Membership:

- Each Community Executive Director/Campus Administrator or Health Care Administrator will be represented and share related information back to the Community ***QAPI*** Committee and subcommittees. Another member of the community may accompany the member to speak about related projects or best practices.
- Operations Support Team Members organize materials for meetings and assist participating members communicate ***QAPI*** processes at their communities.
- The Corporate ***QAPI*** Committee meets at least quarterly.
  - The following areas may be addressed: Quality Improvement Committee and Sub-Committee activities

Committee activities may be reported by the Operation Support Team to the Services Committee of the Board of Trustees through written or verbal reports.

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

September 21, 2016

Ms. Deborah Reitz, Administrator
Glen Meadows Retirement Com.
11630 Glen Arm Road
Glen Arm, MD 21057

PROVIDER # 215278
RE: ACCEPTANCE OF ALLEGATION OF COMPLIANCE

Dear Ms. Reitz:

On August 25, 2016, an Annual Medicare/Medicaid Quality Indicator survey was completed at your facility. You have alleged that the deficiencies cited during that survey have been corrected. We are accepting your plan of correction including the date by which the deficiencies will be corrected as well as the additional evidence you have submitted to ensure that the deficiencies do not recur, and conclude that you have achieved substantial compliance as of September 23, 2016.

Based on your acceptable plan of correction with additional evidence to ensure that the deficiencies identified during the survey do not recur and your allegation of compliance, we are considering your facility in compliance with the Health component of 42 CFR 483, Subpart B, Requirements for Long Term Care.

If you have any questions, please call me at 410-402-8201.

Sincerely,

Frances Curtis
Health Facilities Survey Coordinator
Long Term Care
Office of Health Care Quality

cc: Jane Sacco
License File II

TAB 6

CONSOLIDATED FINANCIAL STATEMENTS

DECEMBER 31, 2015 AND 2014

PRESBYTERIAN SENIOR LIVING SERVICES, INC.

Consolidated Financial Statements

December 31, 2015 and 2014

(With Independent Auditor's Report Thereon)

Arnett Carbis Toothman llp
CPAs & Advisors

PRESBYTERIAN SENIOR LIVING SERVICES, INC.

Table of Contents

Certification of Chief Executive and Chief Financial Officers

We are responsible for the consolidated financial statements of Presbyterian Senior Living Services, Inc., as of December 31, 2015 and 2014, and attest that they are accurate, complete and fairly presented.

The accuracy and completeness of financial information depends on our systems, process, and most importantly our integrity. Our commitment to integrity is reflected in the code of conduct that the leadership of Presbyterian Senior Living has established as the standard for the entire organization. We believe that this commitment, our processes and internal controls produce financial information that can be trusted.

Consolidated financial statements report our financial position and results using numbers and prescribed rules. They also include a significant amount of information that is required by financial reporting standards. We believe these consolidated financial statements disclose information that is important to create a complete picture of our stewardship of financial resources.

Consolidated financial statements alone can never reflect the breadth and depth of our stewardship of this ministry. They do not report on our most significant assets, our employees and volunteers. They also do not reflect our most important stewardship role; our commitment to provide Christian understanding and compassion to those seniors entrusted to our care. We believe that we continue to successfully fulfill the financial and non-financial aspects of our mission, extending a proud tradition of ministry that has served older persons in the name of Christ for the past 89 years.

Finally, we believe in openly and honestly sharing information. Please feel free to contact either of us if you have questions on any part of this report, or if we can be of further assistance in understanding Presbyterian Senior Living's mission.

Stephen E. Proctor
Chief Executive Officer
Presbyterian Senior Living

Jeffrey J. Davis
Chief Financial Officer
Presbyterian Senior Living

Independent Auditor's Report

The Board of Directors
Presbyterian Senior Living Services, Inc.

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Presbyterian Senior Living Services, Inc. (an affiliate of PHI, doing business as Presbyterian Senior Living) (the Corporation) which comprise the consolidated statements of financial position as of December 31, 2015 and 2014, and the related consolidated statements of operations and changes in net assets (liabilities), and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated 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 consolidated financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entities' preparation and fair presentation of the consolidated 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 entities' 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of Presbyterian Senior Living Services, Inc. as of December 31, 2015 and 2014, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Going Concern

The accompanying consolidated financial statements have been prepared assuming that Presbyterian Senior Living Services, Inc. will continue as a going concern. As discussed in Note 18 to the consolidated financial statements, the Corporation has suffered recurring losses from operations; its total liabilities exceeds total assets; and the Corporation's continued operations are dependent upon the continued support of Presbyterian Senior Living. This raises substantial doubt about the Corporation's ability to continue as a going concern. The consolidated financial statements do not include any adjustments that might result from the outcome of this support.

Arnett Carbis Toothman LLP

Arnett Carbis Toothman LLP
New Castle, Pennsylvania
March 31, 2016

Arnett
Carbis
Toothman llp
CPAs & Advisors

PRESBYTERIAN SENIOR LIVING SERVICES, INC.

Consolidated Statements of Financial Position

December 31, 2015 and 2014

Assets		2015	2014
Cash and cash equivalents	$	112,912	243,536
Investments		1,300,000	1,600,000
Restricted deposits and funded reserves		1,805,802	1,654,009
Accounts receivable, net		566,752	716,562
Prepaid expenses and other current assets		206,892	269,125
Assets whose use is limited		1,017,905	1,074,860
Pledges receivable		5,000	—
Assets held for sale		—	39,724
Property and equipment (net of accumulated depreciation of $30,812,878 and $28,931,003, respectively)		29,455,912	30,170,288
Assets under capital leases (net of accumulated amortization of $49,881 and $29,173, respectively)		37,158	57,866
Deferred financing costs (net of accumulated amortization of $264,632 and $248,403, respectively)		200,038	216,267
Total assets	$	34,708,371	36,042,237

See accompanying notes to consolidated financial statements.

(Continued)

PRESBYTERIAN SENIOR LIVING SERVICES, INC.

Consolidated Statements of Financial Position

December 31, 2015 and 2014

Liabilities and Net Liabilities	2015	2014
Accounts payable	$ 631,936	1,065,902
Accrued expenses	475,818	423,782
Resident deposits	24,000	48,320
Entrance fees payable	16,011,397	17,288,651
Deferred revenue – entrance fees	3,858,083	3,695,005
Annuities payable	51,989	27,879
Obligations under capital leases	37,721	58,133
Bonds payable	14,505,000	15,115,000
Due to affiliated entity	22,756,431	21,025,499
Total liabilities	58,352,375	58,748,171
Net assets (liabilities):		
Unrestricted	(24,235,365)	(23,280,382)
Temporarily restricted	217,257	202,344
Permanently restricted	374,104	372,104
Total net liabilities	(23,644,004)	(22,705,934)
Total liabilities and net liabilities	$ 34,708,371	36,042,237

See accompanying notes to consolidated financial statements.

PRESBYTERIAN SENIOR LIVING SERVICES, INC.

Consolidated Statements of Operations and Changes in Net Assets (Liabilities)

Years ended December 31, 2015 and 2014

	2015	2014
Operating revenues, gains, and other support:		
Resident services, including amortization of entrance fees of $841,134 and $829,928, respectively	$ 13,082,574	12,876,366
Interest and dividend income	134,318	163,533
Realized (losses) gains on investments	(62,204)	45,184
Gains on sale of property and equipment	20,404	57,627
Gifts and bequests	51,527	21,144
Net assets released from restrictions	2,448	2,329
Total operating revenues, gains, and other support	13,229,067	13,166,183
Expenses:		
Nursing services	2,419,867	2,515,265
Rehabilitation	707,663	487,236
Recreation and special services	496,942	495,008
Pharmacy	84,736	70,713
Social services	59,512	65,285
Physician services	25,000	25,093
Food services	2,039,377	2,111,100
Building operations and maintenance	2,511,961	2,417,101
Housekeeping	407,414	418,803
Laundry and linen	50,909	53,986
General and administrative	2,227,247	2,210,407
Employee benefits	696,171	619,660
Interest	276,891	286,437
Depreciation	1,902,583	1,783,872
Amortization	16,229	16,229
Total expenses	13,922,502	13,576,195
Deficit of operating revenues, gains, and other support over expenses	(693,435)	(410,012)
Other changes:		
Unrealized losses on investments	(261,548)	(143,513)
Change in unrestricted net liabilities	(954,983)	(553,525)

See accompanying notes to consolidated financial statements.

(Continued)

PRESBYTERIAN SENIOR LIVING SERVICES, INC.

Consolidated Statements of Operations and Changes in Net Assets (Liabilities)

Years ended December 31, 2015 and 2014

	2015	2014
Temporarily restricted net assets:		
Contributions, gifts and bequests	233	700
Interest and dividend income	17,128	16,625
Net assets released from restrictions	(2,448)	(2,329)
Change in temporarily restricted net assets	14,913	14,996
Permanently restricted net assets:		
Contributions	2,000	2,000
Change in permanently restricted net assets	2,000	2,000
Change in net liabilities	(938,070)	(536,529)
Net liabilities, beginning of year	(22,705,934)	(22,169,405)
Net liabilities, end of year	$ (23,644,004)	(22,705,934)

See accompanying notes to consolidated financial statements.

PRESBYTERIAN SENIOR LIVING SERVICES, INC.

Consolidated Statements of Cash Flows

Years ended December 31, 2015 and 2014

	2015	2014
Cash flows from operating activities:		
Change in net liabilities	$ (938,070)	(536,529)
Adjustments to reconcile change in net liabilities to net cash provided by operating activities:		
Depreciation	1,902,583	1,783,872
Provision for bad debts	(16,374)	84,734
Proceeds from non-refundable entrance fees and deposits	4,140,044	3,476,376
Amortization of entrance fees	(841,134)	(829,928)
Unrealized losses on investments	261,548	143,513
Realized losses (gains) on investments	62,204	(45,184)
Realized gains on disposal of property and equipment	(20,404)	(57,627)
Contributions restricted for long-term purposes	(2,000)	(2,000)
Amortization	16,229	16,229
Change in assets and liabilities:		
Accounts receivable	166,184	11,002
Pledges receivable	(5,000)	—
Prepaid expenses and other current assets	62,233	(9,402)
Accounts payable	(433,966)	733,590
Accrued expenses	52,036	(54,755)
Net cash provided by operating activities	4,406,113	4,713,891
Cash flows from investing activities:		
Acquisition of property and equipment	(1,287,153)	(1,259,839)
Net proceeds from sale of property and equipment	179,782	167,741
Purchases of investments	(1,764,012)	(1,610,187)
Proceeds from sale of investments	1,645,422	1,453,990
Net cash used in investing activities	(1,225,961)	(1,248,295)
Cash flows from financing activities:		
Refunds of entrance fees and deposits	(3,160,152)	(2,402,962)
Change in entrance fee payable	(1,277,254)	(1,591,903)
Principal payments and redemptions of bonds	(610,000)	(570,000)
Borrowings through capital lease obligations	—	54,192
Repayments on capital lease obligations	(20,412)	(13,544)
Contributions restricted for long-term purposes	2,000	2,000
Change in annuities payable	24,110	(1,512)
Change in due to affiliated entity	1,730,932	1,108,965
Net cash used in financing activities	(3,310,776)	(3,414,764)
Net (decrease) increase in cash and cash equivalents	(130,624)	50,832
Cash and cash equivalents, beginning of year	243,536	192,704
Cash and cash equivalents, end of year	$ 112,912	243,536
Supplemental schedule of non-cash investing activities		
Decrease in assets held for sale through increase in property and equipment	$ 39,724	9,780

See accompanying notes to consolidated financial statements.

(1) General Information

Presbyterian Senior Living Services, Inc. (the Corporation) is a not-for-profit corporation, which operates Glen Meadows Retirement Community, a Continuing Care Retirement Community (the Community) located in Glen Arm, Maryland, which provides housing, health care, and other related services to the elderly. The Corporation is also the parent company to a fully controlled affiliate, Glen Meadows Retirement Community, Inc. (GMRCI). The Glen Meadows Foundation (the Foundation) was established for the exclusive benefit of the Community and certain assets held by the Corporation are designated for the Foundation. The consolidated financial statements of the Corporation include the financial position and operations of GMRCI and the Foundation. The Corporation and Foundation are governed by independent Boards of Directors, who are elected by the Board of Trustees of PHI, doing business as Presbyterian Senior Living, the Corporation's parent organization, the residents of Glen Meadows and the Presbytery of Baltimore.

The Community contains 112 independent living cottages, 89 independent living apartments, 36 assisted living units and a 31-bed skilled nursing facility. The Community covers approximately 60 acres of the 483-acre site owned by the Corporation.

The Corporation was formed on July 1, 1999, whereby all operations of Presbyterian Senior Services, Inc. (PSSI) were transferred to Presbyterian Senior Living Services, Inc. and Glen Meadows Retirement Community, Inc. PSSI's corporate existence was discontinued. Under this new structure, the property, plant and certain equipment of PSSI were transferred to Glen Meadows Retirement Community, Inc., and the operations, other assets, and all liabilities of PSSI were transferred to Presbyterian Senior Living Services, Inc. Presbyterian Senior Living Services, Inc. is a fully controlled subsidiary of Presbyterian Senior Living, located in Dillsburg, Pennsylvania.

(2) Summary of Significant Accounting Policies

(a) Basis of Consolidation

These consolidated financial statements have been prepared to focus on Presbyterian Senior Living Services, Inc. as a whole. All material intercompany transactions have been eliminated.

(b) Basis of Accounting

These consolidated financial statements, which are presented on the accrual basis of accounting, have been prepared to focus on the Corporation as a whole and to present balances and transactions according to the existence or absence of donor-imposed restrictions.

(continued)

(b) Basis of Accounting (continued)

Revenues are reported as increases in unrestricted net assets (liabilities) unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets (liabilities). Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets (liabilities) unless their use is restricted by explicit donor stipulation or by law.

(c) Income Taxes

The Corporation and its subsidiaries are not-for-profit organizations as described in Section 501(c)(3) of the Internal Revenue Code (Code) and has been recognized as tax exempt under Section 501(a) of the Code.

The Corporation follows the Financial Accounting Standards Board (FASB) accounting standard for accounting for uncertainty in income taxes. This standard clarifies the accounting for uncertainty in income taxes in a company's consolidated financial statements and prescribes a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold has been met. The standard also provides guidance on derecognition, classification, interest and penalties, and disclosure. Management has determined that this standard does not have a material impact on the consolidated financial statements.

The Corporation is part of a consolidated federal Exempt Organization Business Income Tax Return for which the years ended December 31, 2012, 2013 and 2014 remain subject to examination by the Internal Revenue Service.

(d) Use of Estimates

The preparation of consolidated 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 consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(continued)

(e) Cash and Cash Equivalents

The Corporation considers all liquid investments with a maturity of three months or less when purchased to be cash equivalents, for the purposes of the consolidated statements of financial position and cash flows, except for those included in investments or assets whose use is limited. The Corporation's cash and cash equivalents are insured by the Federal Deposit Insurance Corporation (FDIC) for up to $250,000 per bank. At times during 2015 and 2014, the Corporation's cash balances may have exceeded the FDIC coverage. The Corporation has not experienced any loss in these accounts.

(f) Investments

Investments in marketable equity securities and mutual funds with readily determinable fair values and all investments in debt securities are measured at fair value as determined by a national exchange in the consolidated statements of financial position. A decline in market value of any investment below cost that is deemed to be other than temporary results in a reduction in carrying amount to fair value. The impairment is charged to realized loss and a new cost basis for the investment is established. For the years ended December 31, 2015 and 2014, no amounts were charged to realized loss for this purpose as management believes the decline in value is temporary due to general economic conditions and not an other than temporary decline in value.

Investment income (loss) consisted of the following:

	2015	2014
Interest and dividends	$ 151,446	180,158
Realized (losses) gains on investments	(62,204)	45,184
Unrealized losses on investments	(261,548)	(143,513)
	$ (172,306)	81,829

Investment expenses of $14,060 and $14,934, for the years ended December 31, 2015 and 2014, respectively, have been included in general and administrative expenses.

(continued)

(g) Accounts Receivable

Accounts receivable are shown net of an estimated allowance for doubtful accounts, as follows:

	2015	2014
Total accounts receivable	$ 647,053	868,329
Less: allowance for doubtful accounts	(80,301)	(151,767)
Net accounts receivable	$ 566,752	716,562

Receivables are considered past due when payments have not been received by the Corporation within 60 days of their contractually stated due date.

The allowance for doubtful accounts is established based on management's assessment of the collectability of specific customer accounts and the aging of the accounts receivable. Losses are charged against the allowance for doubtful accounts when management believes the uncollectability of a receivable is likely.

(h) Restricted Deposits and Funded Reserves

Restricted deposits and funded reserves are measured at fair value in the consolidated statements of financial position and include the Maryland Department of Aging Operating Reserve.

(i) Assets Whose Use is Limited

Assets whose use is limited are measured at fair value in the consolidated statements of financial position and include money deposited with a trustee under a debt agreement and assets restricted by donors for capital improvements and charity care.

(j) Pledges Receivable

In 2015, a pledge was received for $5,000. Full payment of this gift is expected in early 2016. The Corporation recorded this pledge at full value since it is due within a year.

(continued)

(k) Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value on the date of donation. Depreciation is being provided on the straight-line method over the estimated useful lives of the assets. The Corporation's policy is to capitalize items in excess of $3,000 or for a group of items that are the same or similar in nature or function as a group totaling $3,000 or more.

Depreciable lives are determined as follows:

Land improvements	15-25 years
Buildings and improvements	10-40 years
Departmental equipment, furniture, and fixtures	10-25 years
Vehicles	5 years

(l) Deferred Financing Costs

The Corporation has deferred the costs incurred for obtaining the proceeds of the Corporation's bonds payable. These costs are being amortized over the life of the related bond using the straight-line method, which approximates the effective interest method. Amortization expense is expected to be $16,229 for each of the next five years.

(m) Resident Deposits

Entrance fees and waiting list deposits received from prospective residents prior to occupancy under Residence and Care Agreements are included in resident deposits in the consolidated statements of financial position. These deposits are transferred to deferred revenue upon occupancy of the related independent living units.

(continued)

(n) Deferred Revenue – Entrance Fees

Residents entering the Community execute a Residence and Care Agreement, which requires payment of an entrance fee, based on the unit to be occupied. Ten percent of the entrance fee, as approved by the Maryland Department of Aging, is due upon execution of the agreement and the remainder is due upon occupancy. For the 100% refundable contracts, entrance fees are refundable in full upon termination of the agreement and subsequent reoccupancy of the unit. These entrance fees are not being amortized into revenue and are reflected as a liability on the consolidated statements of financial position. The Community also offers a 50% and a 75% nonrefundable contract. The non-refundable portion of the fees is amortized to income over the estimated remaining life expectancy of each resident. The portion of the guaranteed fee refundable upon reoccupancy is not being amortized and is reflected as a liability on the consolidated statements of financial position. The agreements provide for potential death or termination refunds of the non-refundable portion if reoccupancy occurs before the contractual amortization is completed in accordance with the terms of the agreements. The remaining amount of unamortized, nonrefundable entrance fees is recorded as revenue upon surrender of the independent living unit.

As of December 31, 2015 and 2014, the amount of entrance fees guaranteed to be refundable to residents under contractual refund provisions was $16,011,397 and $17,288,651, respectively.

(o) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time period or purpose. The Corporation's temporarily restricted net assets consist principally of funds directed for special projects and resident welfare. Net assets released from restriction consist of expenses incurred satisfying those restricted purposes. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity. Income from the permanently restricted net assets is primarily to be used for resident welfare.

(continued)

(p) Donor Restrictions

The Corporation reports gifts of cash and other assets as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or the purpose to which the donation is restricted is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations and changes in net assets (liabilities) as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying consolidated financial statements.

The Corporation reports non-cash gifts as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, the Corporation reports expirations of donor restrictions when the donated or acquired long-lived assets are placed in service.

(q) Resident Services Revenue and Business Concentration

Resident services revenue is reported at the estimated net realizable amount to be received from patients and others including Medicare, Maryland Medicaid (Medicaid), and other third-party payors for services rendered. The Corporation derives a significant portion of its revenues from federal and state reimbursement programs. These reimbursements are subject to audit and retroactive adjustment in future periods.

Skilled nursing services provided to Medicare beneficiaries are paid under the terms of a prospective payment system ("PPS") at predetermined rates based on clinical, diagnostic, and other factors.

Nursing services provided to Medicaid beneficiaries are paid at prospectively determined rates per day. These rates vary according to a resident classification system that is based on clinical diagnosis and other factors, and the reimbursement methodology is subject to various limitations and adjustments. The Corporation's existence in Maryland exposes it to the risk of changes in Medicaid reimbursement in this state.

Revenues from Medicare and Medicaid represent approximately 20% and 17% of consolidated revenues for 2015 and 2014, respectively. Medicare and Medicaid receivables represent approximately 39% and 44% of consolidated accounts receivable at December 31, 2015 and 2014, respectively.

(continued)

(r) Charity Care

The Corporation follows the Financial Accounting Standards Board (FASB) accounting standards update. This standard provides improved disclosures about charity care to prescribe a specific measurement basis of charity care. This guidance prescribed that the amount of charity care disclosed in the consolidated financial statements should be measured based on the providers direct and indirect costs of providing charity care services. The guidance also provided that if costs cannot be specifically attributed to services provided to charity care patients, that reasonable techniques could be used to estimate these costs, and that these techniques should be disclosed and that any funds received to offset or subsidize charity care services also should be disclosed.

The Corporation's policy is to provide services without charge, or at amounts less than its established rates, to residents who meet the certain need based criteria. These criteria consider resident income and expenses, financial resources, State and Federal government requirements, and other sources of payment for services which may be provided. The Corporation also receives donations and income from permanently restricted trusts and investments designated to the needs of its residents under this policy.

Amounts the Corporation provided and received for resident financial support are as follows:

	2015	2014
Charity care provided at the estimated cost thereof, net of amounts received from residents and third-party payors	$ 407,561	281,757
Additional benevolent care provided at amounts less than pre-established charges for private pay services	328,524	760,329
Giving and income designated for resident financial support	33,273	12,905

(continued)

(s) Classification of Expenses

Expenses incurred are classified as follows:

	2015	2014
Program activities	$ 11,695,255	11,365,788
General and administrative	2,184,192	2,160,879
Fundraising	43,055	49,528
	$ 13,922,502	13,576,195

(t) Fundraising Expenses

Fundraising expenses incurred by the Corporation are included in general and administrative on the consolidated statements of operations and changes in net assets (liabilities).

(u) Advertising

Advertising costs are expensed in the years incurred. Total advertising expense for the years ended December 31, 2015 and 2014 were $11,707 and $11,463, respectively.

(v) Contributed Services

Contributed services are reflected in the accompanying consolidated financial statements at their estimated fair value at the date of receipt to the extent they create or enhance nonfinancial assets or require specialized skills which, if not provided by donation, would have to be purchased by the Corporation. No amounts have been included in the accompanying consolidated financial statements as amounts are not material.

(w) Performance Indicator

The Corporation measures the performance of its operations using the consolidated statements of operations and changes in net assets (liabilities), which includes a performance indicator of operations labeled as "Deficit of operating revenues, gains, and other support over expenses." Changes in unrestricted net (liabilities) which are excluded from this measure are unrealized losses on investments.

(continued)

(x) Consolidated Statements of Cash Flows

Interest paid during the years ended December 31, 2015 and 2014 were $276,571 and $286,595, respectively.

(y) Subsequent Events

The Corporation has adopted the standard related to subsequent events. This standard provides guidance on accounting for and disclosure of events that occur after the consolidated statement of financial position date but before consolidated financial statements are issued or are available to be issued.

The Corporation has evaluated subsequent events through March 31, 2016, which is the date the consolidated financial statements were released.

(3) Investments

The cost and fair value of investments at December 31 are as follows:

	2015		2014	
	Fair Value	Cost	Fair Value	Cost
Money market funds	$ 359,807	359,807	336,938	336,938
Equity securities	3,174,500	3,165,855	3,087,799	2,847,969
Fixed income securities	589,400	616,615	904,132	922,890
Totals	$ 4,123,707	4,142,277	4,328,869	4,107,797
Less:				
Restricted deposits and funded reserves (Note 5)	(1,805,802)		(1,654,009)	
Assets whose use is limited (Note 6)	(1,017,905)		(1,074,860)	
Total investments	$ 1,300,000		1,600,000	

The Corporation holds its investments in the operating reserve fund. These assets are invested in a diversified portfolio of mutual funds. The Corporation had twenty mutual funds as of December 31, 2015 and 2014. As of December 31, 2015, twelve mutual funds had a market value below cost and as of December 31, 2014, eight mutual funds had a market value below cost.

(continued)

(3) Investments (continued)

Eleven mutual funds had a market value that had been below cost for less than a year as of December 31, 2015. In total, their market value of the loss was less than nine percent below cost for 2015. Six mutual funds had a market value that had been below cost for less than a year as of December 31, 2014. In total, their market value of the loss was less than five percent below cost for 2014.

One mutual fund had a market value that had been below cost for more than one year as of December 31, 2015. In total, its market value was less than four percent below cost for 2015. Two mutual funds had a market value that had been below cost for more than one year as of December 31, 2014. In total, their market value was less than ten percent below cost for 2014.

A summary of investments with fair values below cost as of December 31, 2015 follows:

	Less than 12 Months		More than 12 Months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Mututal funds	$ 1,989,884	(195,240)	397,991	(14,867)	2,387,875	(210,107)
Total temporarily impaired investments	$ 1,989,884	(195,240)	397,991	(14,867)	2,387,875	(210,107)

A summary of investments with fair values below cost as of December 31, 2014 follows:

	Less than 12 Months		More than 12 Months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Mututal funds	$ 1,203,625	(60,418)	495,067	(52,752)	1,698,692	(113,170)
Total temporarily impaired investments	$ 1,203,625	(60,418)	495,067	(52,752)	1,698,692	(113,170)

(continued)

(4) Related Party Transactions

The Corporation incurs a management fee payable to Presbyterian Senior Living, under a Development, Marketing, and Management Agreement (Management Agreement). Under the Management Agreement, Presbyterian Senior Living provides a full-time licensed administrator who is responsible for the Community's operation, under the direction of Presbyterian Senior Living, a full-time bookkeeper and a human resources employee. For 2015, the Corporation incurred fees under the agreement of $1,175,220. For 2014, the Corporation incurred fees under the agreement of $1,000,140. This fee is classified as general and administrative expenses on the consolidated statements of operations and changes in net assets (liabilities).

The Obligated Group, which consists of several subsidiaries of Presbyterian Senior Living, has guaranteed full payment to the extent collateral is insufficient to satisfy the outstanding debt of the Corporation as described in Note 9.

At December 31, 2015 and 2014 the amounts payable to Presbyterian Senior Living were $22,756,431 and $21,025,499, respectively. Under the Management Agreement, this is included in due to affiliated entity on the consolidated statements of financial position.

Prelude Systems, Inc. (Prelude) is a joint venture between Presbyterian Senior Living and Diakon Lutheran Social Ministries (Diakon). Prelude is an information technology services organization with a wide range of programs designed to support the information systems needs of Presbyterian Senior Living and Diakon as well as other health care and community service organizations. During 2015 and 2014, the Corporation incurred expenses related to Prelude of $132,564 and $103,944, respectively, for information services provided by Prelude, of which $7,339 and $6,324 is included in accounts payable as of December 31, 2015 and 2014, respectively.

(continued)

(5) Restricted Deposits and Funded Reserves

The Corporation is required by the Maryland Department of Aging to maintain and fund an operating reserve based on the Corporation's operating expenses for the most recent fiscal year, excluding depreciation and amortization. The Department of Aging required the Corporation to build the level of this operating reserve over a period not to exceed ten years beginning in 1997. Annual contributions to the operating reserve equaling at least 15% of the calculated reserve amount are required. At December 31, 2015 the operating reserve fund balance was $1,805,802, representing cumulative contributions and earnings in satisfaction of the minimum operating reserve amount. No additional contributions are anticipated to be made during 2016 based on the following computation:

Total 2014 operating expenses:		$	13,576,195
Less:	Depreciation		(1,783,872)
	Amortization		(16,229)
	Total expenses subject to operating reserve computation	(A)	11,776,094
Operating reserve requirement – 15% of (A)			1,766,414
Operating reserve fund, December 31, 2015			1,805,802
Contributions required for year ended December 31, 2016		$	(39,388)

(6) Assets Whose Use is Limited

At December 31 assets whose use is limited consist of the following:

		2015	2014
Designated for renovation and charity care	$	696,134	766,892
Other reserves required by financing arrangement		321,771	307,968
Assets whose use is limited	$	1,017,905	1,074,860

The Corporation's Board of Directors has designated certain funds toward the purpose of acquiring or renovating property and equipment and for providing charity care.

(continued)

(7) Commitments and Contingencies

The Corporation is involved in legal proceedings arising from its activities in the health care industry. Although it is not possible to presently determine the outcome of these matters, management believes the aggregate liability, if any, resulting from such proceedings will not have a material adverse effect on the Corporation's assets, liabilities, net assets, operations, or cash flows.

(8) Property and Equipment

A summary of property and equipment and accumulated depreciation at December 31 is as follows:

	2015		2014	
	Cost	Accumulated depreciation	Cost	Accumulated depreciation
Land	$ 14,182,370	—	14,298,837	—
Land improvements	3,016,607	2,100,209	2,977,583	1,962,101
Buildings and improvements	39,941,622	26,206,159	38,709,251	24,553,897
Departmental equipment, furniture and fixtures	2,640,996	2,250,517	2,489,528	2,159,012
Vehicles	255,993	255,993	255,993	255,993
Construction-in-progress	231,202	—	370,099	—
	$ 60,268,790	30,812,878	59,101,291	28,931,003
Net book value		$ 29,455,912		$ 30,170,288

Land consists of 483 acres, of which 60 acres are utilized for the Community. The remaining land is leased to independent parties and may be available for future expansion.

In 2013, management decided to sell the six rental properties that are located within the community. During 2013, four of the six units were sold. In 2014, another unit was sold for approximately $168,000 and a gain on the sale of $57,627 was recognized. In 2015, the final unit was sold for approximately $180,000 and a gain on the sale of $20,404 was recognized.

(continued)

(9) Bonds Payable

Bonds payable as of December 31 consist of the following:

	2015	2014
Maryland Health and Higher Educational Facilities Authority Revenue Bonds Series 1999A, tax exempt variable rate debenture bonds, principal maturities in varying amounts from 2012 to 2029, interest adjusted weekly, 0.01% and 0.03% at December 31, 2015 and 2014, respectively, collateralized by letter of credit	$ 2,835,000	2,970,000
Maryland Health and Higher Educational Facilities Authority Revenue Bonds Series 1999B, taxable variable rate debenture bonds, principal maturities in varying amounts from 2001 to 2029, interest adjusted weekly, 0.35% and 0.12% at December 31, 2015 and 2014 respectively, collateralized by letter of credit	11,670,000	12,145,000
Total bonds payable	$ 14,505,000	15,115,000

Under the terms of the Corporation's 1999 Maryland Health and Higher Educational Facility Authority Revenue Bond indenture, the Corporation is required to maintain certain deposits with a trustee. These deposits are included in assets whose use is limited. The indenture also places limits on the incurrence of additional borrowings and requires the Corporation to satisfy certain measures of financial performance as long as the bonds are outstanding. These covenants were met as of December 31, 2015 and 2014.

Maturities for the five years subsequent to December 31, 2015 and thereafter are as follows:

Years ending December 31,	
2016	$ 650,000
2017	695,000
2018	745,000
2019	795,000
2020	845,000
Thereafter	10,775,000
	$ 14,505,000

(continued)

(9) Bonds Payable (continued)

The Corporation has outstanding two letters of credit at December 31, 2015 as required by the bonds. These letters of credit require the Corporation to pay an annual fee approximating 1.55% of the principal balance of bonds outstanding. The letters of credit expire March 31, 2018. The letters of credit are collateralized by property and equipment and gross revenues of the Corporation. As described in Note 4, the Obligated Group, which consists of several subsidiaries of Presbyterian Senior Living, has guaranteed full payment to the extent collateral is insufficient to satisfy the outstanding debt of the Corporation.

(10) Leases

The Corporation is obligated under capital leases for equipment and vehicles that will expire in 2018. At December 31, 2015 and 2014, the gross amount of the equipment and vehicles and related accumulated amortization recorded under capital leases was as follows:

	2015	2014
Equipment and vehicles	$ 87,039	87,039
Accumulated amortization	(49,881)	(29,173)
	$ 37,158	57,866

A schedule of future minimum lease payments under capital leases together with the present value of the net minimum lease payments as of December 31, 2015 follows:

2016	$ 17,271
2017	16,200
2018	5,400
	38,871
Amounts representing interest	(1,150)
Present value of minimum lease payments	$ 37,721

Amortization expense of $20,708 and $13,529 for the years ended December 31, 2015 and 2014, respectively, for the assets held under capital leases is included in depreciation expense in the consolidated statements of operations and changes in net assets (liabilities). Interest rates on the capital leases range from 2.5% to 2.6% for the year ended December 31, 2015 and 2014.

(continued)

(10) Leases (continued)

The Corporation leases certain equipment under operating leases, which expire at various dates through 2017. The future minimum lease payments under these operating leases are as follows:

2016	$ 38,088
2017	14,496
	$ 52,584

Rental expense under operating leases was $52,988 and $56,217 for the years ended December 31, 2015 and 2014, respectively.

(11) Annuities

The Corporation has a gift annuity program. In return for their gifts, donors are paid a fixed annuity amount during the lifetime of the donor and/or the donor's beneficiary, which creates a liability of the Corporation. Total annuities payable was $51,989 and $27,879 at December 31, 2015 and 2014, respectively. The Corporation uses published mortality-rate tables adopted by the United States Internal Revenue Service and an assumed discount rate of approximately four percent to determine the present value of the actuarially determined liability. The Corporation has assets included in investments of approximately $167,000 and $139,000 as of December 31, 2015 and 2014, respectively, to satisfy annuities.

(12) Retirement Plan

The Corporation participates in the defined-contribution retirement plan of Presbyterian Senior Living. This plan covers all employees that have completed one year of service and have reached the age of 21. Vesting occurs after three years of service. Contributions to the plan are at the discretion of the Board of Trustees of Presbyterian Senior Living, and employees have the ability to direct how their contributions are invested. For the years ended December 31, 2015 and 2014, retirement plan expense totaled approximately $92,800 and $77,400, respectively.

(continued)

(13) Medical Malpractice Claims Coverage

The Corporation maintains professional liability coverage on a claims-made basis through a commercial insurance carrier. Other than for premiums paid under this policy, no provision has been made for estimated losses. Management believes no incidents have occurred or will be asserted that will exceed the Corporation's insurance coverages or will have a material adverse effect on the consolidated financial statements.

(14) Temporarily Restricted Net Assets

Temporarily restricted net assets as of December 31 are available for the following purposes:

Endowment:		2015	2014
Benevolent Care	$	204,390	188,726
Scholarships		1,171	2,155
		205,561	190,881
Other		11,696	11,463
	$	217,257	202,344

Net assets of $2,448 and $2,329 were released from restriction during 2015 and 2014, respectively, in satisfaction of the above restrictions.

(15) Permanently Restricted Net Assets

Permanently restricted net assets are allocated for the following purposes at December 31:

Endowment:		2015	2014
Benevolent Care	$	326,253	326,253
Scholarship		47,851	45,851
	$	374,104	372,104

(continued)

(16) Endowment

The endowments consist of donor restricted funds established for a variety of purposes supporting the Corporation. As required by accounting principles generally accepted in the United States of America, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law

The Board of Trustees of 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 funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as unrestricted and temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by the relevant state law and donor imposed stipulations. 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 organization and the donor-restricted endowment fund
(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 organization
(7) The investment policies of the organization

(continued)

(16) Endowment (continued)

The following schedule represents the changes in endowment net assets for the year ended December 31, 2015.

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	$ 190,881	372,104	562,985
Investment return:			
Investment income	17,128	–	17,128
Contributions	–	2,000	2,000
Appropriation of endowment assets for expenditures	(2,448)	–	(2,448)
Endowment net assets, end of year	$ 205,561	374,104	579,665

The following schedule represents the changes in endowment net assets for the year ended December 31, 2014.

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	$ 176,356	370,104	546,460
Investment return:			
Investment income	16,625	–	16,625
Contributions	–	2,000	2,000
Appropriation of endowment assets for expenditures	(2,100)	–	(2,100)
Endowment net assets, end of year	$ 190,881	372,104	562,985

(continued)

(16) Endowment (continued)

Funds with Deficiencies

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 accounting principles generally accepted in the United States of America, these deficiencies are reported as unrestricted net assets. There were no such deficiencies reported at December 31, 2015 or 2014.

Return Objectives and Risk Parameters

The Corporation has adopted investment 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 or for a donor-specified period(s) as well as board-designated funds. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results of a composite of public market indexes based on the mix of investments held, while assuming a moderate level of investment risk. The Corporation expects its endowment funds, over time, to provide an average rate of return of approximately the consumer price index plus the investment spending percentage plus one percent annually. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives

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). 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.

(continued)

(16) Endowment (continued)

Endowment Spending Policy and How the Investment Objectives Relate to the Spending Policy

The Corporation has a total return policy for calculating the amounts available for distribution each year. It is a percent of its endowment fund's average fair value over the prior three calendar year ends. This percentage was 3.0% for both 2015 and 2014. Actual distributions are for specific projects approved by the Board of Directors. If the total return amount exceeds the actual earnings of the Endowment Funds in any one year, then the amount needed to fund such excess will first be taken from the accumulated excess earnings from prior years, then from the accumulated net capital gains of Endowment Funds and, conversely, any undistributed income after the allocation of the total return distribution is added back to the unrestricted or temporarily restricted fund balance. In establishing this policy, the Corporation considered the long-term expected return on its endowment assets. Accordingly, over the long term, the Corporation expects the current spending policy to allow its endowment funds to grow at an average of inflation plus one percent annually. For both 2015 and 2014 an allocation of three percent of the prior year's balance was used to calculate restricted funds available balance. This is consistent with the Corporation's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

(17) Financial Instruments

(a) Fair Values of Financial Instruments

The following valuation techniques were used to measure the fair value of each class of financial instruments:

Money market funds, equity and fixed income securities: Fair value of money market funds and equity and fixed income securities was based on quoted market prices for the identical security.

Long-term debt: Long-term debt is carried at cost in the consolidated statements of financial position for bonds payable at December 31, 2015 and 2014. Fair value is based on quoted market prices for the same or similar issues. The total outstanding was $14,505,000 and $15,115,000 at December 31, 2015 and 2014, respectively. The carrying amounts of these bonds payable approximate their fair value.

(continued)

(17) Financial Instruments (continued)

The Corporation has a number of other financial instruments, none of which are held for investment purposes. The Corporation estimates that the fair value of all financial instruments at December 31, 2015 and 2014 does not differ materially from the aggregate carrying values of its financial instruments recorded in the accompanying consolidated statements of financial position.

The standards for accounting for fair value measurements established 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 under these standards 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).

An asset's or liability's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement. There have been no changes in the methodologies used to measure fair value at December 31, 2015 or 2014.

For assets measured at fair value on a recurring basis, the fair value measurements by level within the fair value hierarchy used at December 31, 2015 are as follows:

Description		Total	Level 1
Money market funds	$	359,807	359,807
Equity securities		3,174,500	3,174,500
Fixed income securities		589,400	589,400
Total investments	$	4,123,707	4,123,707

(continued)

(17) 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 at December 31, 2014 are as follows:

Description		Total	Level 1
Money market funds	$	336,938	336,938
Equity securities		3,087,799	3,087,799
Fixed income securities		904,132	904,132
Total investments	$	4,328,869	4,328,869

(b) Financial Instruments with Off-Balance-Sheet Risk

Financial instruments with off-balance-sheet risk to the Corporation consist of certain financial guarantees of its affiliates and letters of credit obtained from various financial institutions. The Corporation's exposure to credit loss in the event of nonperformance by the other party to the financial instrument is represented by the contractual amount of those obligations.

(18) Other Matters

The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America, which contemplates continuation of the Corporation as a going concern. As of December 31, 2015 and 2014, the Corporation carried unrestricted net liabilities of $24,235,365 and $23,280,382, respectively. The unrestricted net liabilities are reflective of the amount due to an affiliated entity of $22,756,431 and $21,025,499.

As such, the continued operations of the Corporation are dependent on continued Presbyterian Senior Living financial support and subordination of its related party debt to operating requirements and external debt repayments. Presbyterian Senior Living has agreed that the related party debt shall be subordinated to principal and interest payments on the Corporation's long-term indebtedness.

TAB 7

LETTERS OF SUPPORT

5697 MacCaughey Drive
North Port, Florida 34287
mcr1030@comcast.net
443-618-0662 (cell)

March 23, 2017

VIA E-MAIL (kevin.mcdonald@maryland.gov) & FIRST CLASS MAIL
Kevin McDonald, Chief, Certificate of Need
Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Presbyterian Senior Living Services, Inc. d/b/a Glen Meadows Retirement Community

Dear Mr. McDonald:

I am writing this correspondence in support of Glen Meadows' application for the purchase of skilled nursing beds from Presbyterian Home of Maryland, Inc.

During the last several years that I was the Chief of Continuing Care for the Maryland Department of Aging, I met with representatives of Glen Meadows on a number of occasions to review their financial situation and to explore ways to make the community fiscally sound. While a number of options were reviewed, there did not seem to be an option that would not cause more financial hardship on an entity that was already financially compromised. In fact, many of the options required Glen Meadows to expend more money at the outset.

After exploring numerous ways to better situate the community, I suggested that Glen Meadows consider trying to buy skilled nursing beds to increase financial viability. Because Glen Meadows is a continuing care retirement community, it is limited by the regulations to providing skilled nursing care only to its residents. Traditionally, Glen Meadows has not kept its skilled nursing beds fully occupied with its residents. With the addition of a Residential Service Agency and the availability of home health services along with other community-based services, the need for skilled nursing beds for the residents has diminished. In addition, the focus of Medicare and other third-party payors on keeping residents in their homes longer, and thus averting institutionalized care, has also impacted upon the need for residents to leave their homes.

With the option to purchase beds without changing the number of skilled nursing beds at the facility, this situation offers Glen Meadows the perfect opportunity to admit outside patients for rehabilitative care without placing an additional financial burden on the facility.

The facility has always been committed to providing continuing care for its residents and has incurred additional financial costs in providing charitable care to those residents who cannot afford to continue to pay the costly health care payments in assisted living and skilled nursing.

The purchase of these skilled nursing beds will allow the facility to continue to provide quality supportive services and a meaningful experience for seniors.

Thank you for your consideration in this matter.

Very truly yours,

Martha C. Roach

Martha C. Roach

From: Barbara Brocato <barbara@bmbassoc.com>
Sent: Tuesday, April 4, 2017 9:31 AM
To: kevin.mcdonald@maryland.gov
Cc: Ben Steffen
Subject: Glen Meadows Letter of Support

Dear Mr. McDonald:

I am writing on behalf of the Glen Meadows Residents Association to urge you to support and expedite its application to purchase health care beds from the Presbyterian Home of Maryland. I have been a consultant to the Maryland Continuing Care Residents Association (MACCRA) since 1995. Given my long history with MACCRA and its affiliate organizations, I can attest to Glen Meadows' sincere need for additional beds.

The beds that have been requested would enable Glen Meadows to accept non-residents into its Health Care Center and thereby generate positive cash flow. Glen Meadows' high quality of care and the resultant good health of its residents has created unforeseen cash flow patterns. Specifically: due to its residents' good health, Glen Meadows' Health Care Center experiences a high vacancy rate. Because Glen Meadows' Assisted Living program is at or near capacity, the CCRC's only hope for consistent and substantial revenue growth is through its Health Care Center.

Glen Meadows' fiscal solvency has strong implications for not just current residents but also future residents and the surrounding community. Glen Meadows is a critical source of high quality essential services in a geographic area largely devoid of assisted living and continuing care facilities. There are no health care facilities in Glen Arm, Baldwin, Phoenix, or Fallston. Were Glen Meadows to fall into fiscal insolvency – due not to negligence or lack of oversight, but to operating efficiently and frugally in the best interests of its patients – it would be a huge loss for the area.

For the sake of the Glen Meadows' current and future residents, patients, and their families, I respectfully request that you and the Commission give Glen Meadows' application for health care beds a swift and favorable review.

Thank you for your consideration of this urgent and important matter. Please do not hesitate to contact me with any questions.

Sincerely,
Barbara

Barbara Marx Brocato & Associates
18 Pinkney St
Annapolis, MD 21401
(410) 269-1503
(410) 269-5021 - Fax
barbara@bmbassoc.com

Glen Meadows Residents' Association
11630 Glen Arm Road—L65
Glen Arm MD 21957

March 27, 2016

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

Dear Mr. McDonald:

I am writing on behalf of the Glen Meadows Residents' Association in strong support of the application by the Glen Meadows Retirement Community to purchase health care beds from the Presbyterian Home of Maryland. It is our understanding that this would enable us to accept non-residents of Glen Meadows into our Health Care Center.

We realize that you and the Commission have an important responsibility to evaluate the need for health care beds in the area. While we understand the necessity for this process, we implore you and the Commission to consider another need—the desperate need of our Glen Meadows Community to create a positive cash flow in our budget. We appeal to you from a position of desperation and peril.

We are totally owned by Presbyterian Senior Living of Dillsburg, PA, and could not survive without their substantial loans. In 2016, we ran a deficit slightly in excess of $2,000,000. In our external audit for 2015, our auditor, Arnett Carbis Toothman, had the following ominous message:

"Going Concern

The accompanying consolidated statements have been prepared assuming that Presbyterian Senior Living Services, Inc. (Glen Meadows' Maryland corporation) will continue as a going concern, As discussed in Note 18 ....the Corporation has suffered recurring losses from operations; its total liabilities exceed total assets....This raises substantial doubt about the Corporation's (Glen Meadows) ability to continue as a going concern..."

Yet, we see light at the end of the tunnel. As you probably know, we are allowed to accept non-residents in Assisted Living. A year ago, we had 12 vacancies in AL; now we operate at or near capacity thanks to our management and a residents' Task Force on Assisted Living. Our splendid marketing team keeps Independent Living at or near capacity. Glen Meadows is operated in a very efficient and frugal manner, so our only hope for substantial revenue growth is through our Health Care Center. Management's Masterpiece Living Program has helped us to be a very healthy bunch causing the high vacancy rate in Health Care—ordinarily a very good circumstance, except for the dangerous cash flow consequences.

We urge you to give special consideration to our isolated geographic location about half-way between Towson and Bel Air. There are no health care facilities in Glen Arm, Baldwin, Phoenix, or Fallston. Our beautiful campus and outstanding Health Center offer an attractive option to patients and caregivers in our area.

We address the most compassionate side of your nature on behalf of the 271 residents of Glen Meadows. We love our homes and each other. We need your help as we seek financial stability in keeping Glen Meadows a "going concern."

Thank you for your consideration of this heartfelt request.

Sincerely yours,

Robert Y. Dubel

Robert Y. Dubel
President, Glen Meadows Residents' Association
410-319-5354
robertdubel@hotmail.com

c: Peter Dabbenigno, Executive Director

MARYLAND CONTINUING CARE RESIDENTS ASSOCIATION

Protecting the Future of Continuing Care Residents

Voice of CCRC Residents at Annapolis

March 30, 2017

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission

Dear Mr. McDonald:

On behalf of the Glen Meadows Residents Association, I am in strong support of the application by the Glen Meadows Retirement Community to purchase health care beds from the Presbyterian Home of Maryland. It is my understanding that this would enable them to accept non-residents of Glen Meadows into their health care center.

You and the Commission have an important responsibility to evaluate the need for health care beds in the area. Glen Meadows CCRC has a desperate need to create a positive cash flow in their budget to survive under the ownership of Presbyterian Senior Living of Dillsburg, PA. I urge you to give special consideration to this facility which serves the area between Towson and Bel Air where there are no health care facilities.

This beautiful campus offers an attractive option to patients and caregivers in this area. Glen Meadows needs your help as they seek financial stability in keeping their community a going concern in protecting the future of their continuing care residents.

Thank you for your consideration in this most important request.

Alma Smith
State President
Maryland Continuing Care Residents Association
13801 York Road
Cockeysville, MD 21030

TAB 8

AFFIRMATION STATEMENTS

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.

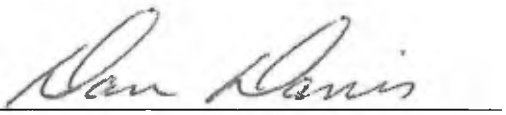
James S. Bernard

Signature

4/6/2017

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

04/04/2017

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.

Peter J. Dabenigno
Signature

04-04-2017
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.

Donna Casnar VP+Controller
Signature

4-4-2017
Date

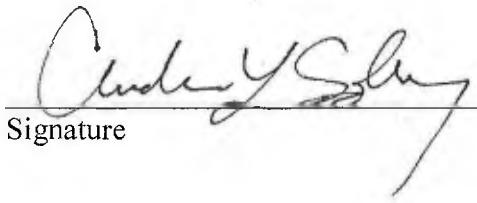
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Signature

4/4/17

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

4/3//2017

Date