



**APPLICATION FOR CERTIFICATE OF NEED: HOSPICE SERVICES
UPDATED JULY 2024**

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 following application form
- Attachments, Exhibits, or Supplements

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.)

SUBMISSION FORMAT:

We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

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 as *searchable PDFs*.
- **Microsoft Word:** The application responses and 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.

PDFs and spreadsheets should be submitted to mhcc.confilings@maryland.gov

Note that there are certain actions that may be taken without CON review and approval. 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.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Hospice Provider: _____

Address:

Street City Zip County

Name of Owner (if differs from applicant): _____

2. OWNER

Name of owner: _____

3. APPLICANT. *If the application has a co-applicant, provide the detail in section 3 and 4 as an attachment.*

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

Address:

Street City Zip State County

Telephone: _____

Name of Owner/Chief Executive: _____

Is this applicant one of the following? (Circle or highlight description that applies.)

- Licensed and Medicare certified general hospice in Maryland
- Licensed and Medicare certified hospice in another state
- Licensed hospital in Maryland/ other state
- Licensed nursing home in Maryland/other state
- Licensed and Medicare certified home health agency in Maryland/other state
- Limited license hospice in Maryland

IF NONE OF THE ABOVE, NOT ELIGIBLE TO APPLY (See COMAR 10.24.13.04A.) DO NOT COMPLETE REMAINDER OF APPLICATION

4. LEGAL STRUCTURE OF LICENSEE

Check or fill in one category below.

- A. Governmental
- B. Corporation
 - (1) Non-profit
 - (2) For-profit
- C. Partnership
 - General
 - Limited
 - Other (Specify):
- D. Limited Liability Company
- E. Other (Specify):

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

A. Lead or primary contact:

Name and Title: _____

Mailing Address: _____

Street _____ City _____ Zip _____ State _____

Telephone: _____

E-mail Address (required): _____

Fax: _____

B. Additional or alternate contact: _____

Mailing Address: _____

Street _____ City _____ Zip _____ State _____

Telephone: _____

E-mail Address (required): _____

Fax: _____

6. Brief Project Description (for identification only; see also item #13):

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

Legal Name of the Owner of the Real Property

Address:

Street _____ City _____ Zip _____ State _____ County _____

Telephone: _____

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 Beds

If the legal entity that has or will have the right to sell the beds is other than the licensee or the owner of the real property identified above provide the following information.

Address:

Street _____ City _____ Zip _____ State _____ County _____

Telephone: _____

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

Name of Management Company _____

Address:

Street _____ City _____ Zip _____ State _____ County _____

Telephone: _____

***Please provide a chart showing the breakdown of ownership that includes the owners of the real property, bed rights and operations. Please include the management company if applicable.**

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

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
- (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

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

12. Complete Table A of the CON Table Package

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

14. REQUIRED APPROVALS AND SITE CONTROL

- A. Site size: _____ acres
- B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES _____ NO _____ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

| |
|--|
| |
|--|

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

- (1) Owned by: _____
- (2) Options to purchase held by: _____
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 IMPLEMENTATION SCHEDULE

An application for a CON or other Commission approval shall propose a schedule for implementation of the project in accordance with COMAR 10.24.01.12A(1) that specifies the estimated time for, at a minimum, the following project implementation steps: Obligation of Capital Expenditure, Beginning Construction, Complete Construction and Full Operation.

In developing the schedule, please note that COMAR 10.24.01.12C requires a holder to obligate at least 51 percent of the approved capital expenditure for a project involving building construction, renovation, or both, as documented by a binding construction contract or equipment purchase order, within the following specified time periods:

- (a) An approved new hospital has up to 36 months
- (b) A project involving an approved new non-hospital health care facility or involving a building addition or replacement of building space of a health care facility has up to 24 months
- (c) A project limited to renovation of existing building space of a health care facility has up to 18 months
- (d) A project that does not involve construction or renovation shall document that the approved project is complete and operational within 18 months.

In a multiphase plan of construction with more than one construction contract approved for an existing health care facility, a holder has:

- (a) Up to 12 months after approval to obligate 51 percent of the capital expenditure for the first phase of construction
- (b) Up to 12 months after completion of the immediately preceding phase of construction to obligate 51 percent of the capital expenditure for any subsequent approved phase

16. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility 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.

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.

18. Project Services (check applicable description):

| Service | (check if description applies) |
|--|--------------------------------|
| Establish a general hospice | |
| Establish a General Inpatient Unit (GIP) | |
| Add beds to a GIP | |
| | |

19. Current Capacity and Proposed Changes:

- a. List the jurisdictions in which the applicant is currently authorized to provide general hospice services. (If services provided in other state(s), list them.)

- b. Jurisdiction applicant is applying to be authorized in:

20. Project Location and Site Control (*Applies only to applications proposing establishment or expansion of a GIP unit:*)

- A. Site Size _____ acres

Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES _____ NO (If NO, describe below the current status and timetable for receiving necessary approvals.)

B. Site Control and utilities:

- (1) Title held by: _____

- (2) Options to purchase held by: _____

(i) Expiration Date of Option _____

(ii) Is Option Renewable? _____ If yes, please explain

(iii) Cost of Option _____

- (3) Land Lease held by: _____

(i) Expiration Date of Lease _____

(ii) Is Lease Renewable? _____ If yes, please explain

(iii) Cost of Lease _____

(4) Option to lease held by: _____

(i) Expiration date of Option _____

(ii) Is Option Renewable? _____ If yes, please explain

(iii) Cost of Option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained.

(6) Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

PART II - PROJECT BUDGET: COMPLETE TABLE 1 - PROJECT BUDGET

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

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

10.24.01.08G(3)(a). The State Health Plan.

Applicant must address each standard from the applicable chapter of the State Health Plan (10.24.13 .05); these standards are excerpted below. (All applicants must address standards A. through O. Applicants proposing a General Inpatient facility must also address P.)

Please provide a direct and concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application. Copies of the State Health Plan are available on the Commission's web site <http://mhcc.dhmf.maryland.gov/shp/Pages/default.aspx>

10.24.13 .05 Hospice Standards. The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new general hospice program, expand an existing hospice program to one or more additional jurisdictions, or to change the inpatient bed capacity operated by a general hospice.

A. Service Area. An applicant shall designate the jurisdiction in which it proposes to provide services.

- B. Admission Criteria.** An applicant shall identify:
- (1) Its admission criteria; and
 - (2) Proposed limits by age, disease, or caregiver.
- C. Minimum Services.**
- (1) An applicant shall provide the following services directly:
 - (a) Skilled nursing care;
 - (b) Medical social services;
 - (c) Counseling (including bereavement and nutrition counseling);
 - (2) An applicant shall provide the following services, either directly or through contractual arrangements:
 - (a) Physician services and medical direction;
 - (b) Hospice aide and homemaker services;
 - (c) Spiritual services;
 - (d) On-call nursing response
 - (e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management);
 - (f) Personal care;
 - (g) Volunteer services;
 - (h) Bereavement services;
 - (i) Pharmacy services;
 - (j) Laboratory, radiology, and chemotherapy services as needed for palliative care;
 - (k) Medical supplies and equipment; and
 - (l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.
 - (3) An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient.
- D. Setting.** An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.
- E. Volunteers.** An applicant shall have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program.
- F. Caregivers.** An applicant shall provide, in a patient's residence, appropriate instruction to, and support for, persons who are primary caretakers for a hospice patient.
- G. Impact.** An applicant shall address the impact of its proposed hospice program, or change in inpatient bed capacity, on each existing general hospice authorized to serve each jurisdiction affected by the project. This shall include projections of the project's impact on future demand for the hospice services provided by the existing general hospices authorized to serve each jurisdiction affected by the proposed project.
- H. Financial Accessibility.** An applicant shall be or agree to become licensed and Medicare-certified and agree to accept patients whose expected primary source of payment is Medicare or Medicaid.
- I. Information to Providers and the General Public.**
- (1) General Information. An applicant shall document its process for informing the following entities about the program's services, service area, reimbursement policy, office location, and telephone number:
 - (a) Each hospital, nursing home, home health agency, local health

- department, and assisted living provider within its proposed service area;
- (b) At least five physicians who practice in its proposed service area;
- (c) The Senior Information and Assistance Offices located in its proposed service area; and
- (d) The general public in its proposed service area.

(2) Fees. An applicant shall make its fees known to prospective patients and their families before services are begun.

J. Charity Care and Sliding Fee Scale. Each applicant shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to hospice services regardless of an individual's ability to pay and shall provide hospice services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospice shall make a determination of probable eligibility.

(2) Notice of Charity Care Policy. Public notice and information regarding the hospice's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the population in the hospice's service area, and in a format understandable by the service area population. Notices regarding the hospice's charity care policy shall be posted in the business office of the hospice and on the hospice's website, if such a site is maintained. Prior to the provision of hospice services, a hospice shall address any financial concerns of patients and patient families and provide individual notice regarding the hospice's charity care policy to the patient and family.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each hospice's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income patients who do not qualify for full charity care but are unable to bear the full cost of services.

(4) Policy Provisions. An applicant proposing to establish a general hospice, expand hospice services to a previously unauthorized jurisdiction, or change or establish inpatient bed capacity in a previously authorized jurisdiction shall make a commitment to provide charity care in its hospice to indigent patients. The applicant shall demonstrate that:

- (a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and
- (b) It has a specific plan for achieving the level of charity care to which it is committed.

K. Quality.

(1) An applicant that is an existing Maryland licensed general hospice provider shall document compliance with all federal and State quality of care standards.

(2) An applicant that is not an existing Maryland licensed general hospice provider shall document compliance with federal and applicable state standards in all states in which it, or its subsidiaries or related entities, is licensed to provide hospice services or other applicable licensed health care services.

(3) An applicant that is not a current licensed hospice provider in any state shall demonstrate how it will comply with all federal and State quality of care standards.

(4) An applicant shall document the availability of a quality assurance and improvement program consistent with the requirements of COMAR 10.07.21.09.

(5) An applicant shall demonstrate how it will comply with federal and State hospice quality measures that have been published and adopted by the Commission.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient hospice care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

(2) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance Programs, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

M. Respite Care. An applicant shall document its system for providing respite care for the family and other caregivers of patients.

N. Public Education Programs. An applicant shall document its plan to provide public education programs designed to increase awareness and consciousness of the needs of dying individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce the disparities in hospice utilization. Such a plan shall detail the appropriate methods it will use to reach and educate diverse racial, religious, and ethnic groups that have used hospice services at a lower rate than the overall population in the proposed hospice's service area.

O. Patients' Rights. An applicant shall document its ability to comply with the patients' rights requirements as defined in COMAR 10.07.21.21.

P. Inpatient Unit: In addition to the applicable standards in .05A through O above, the Commission will use the following standards to review an application by a licensed general hospice to establish inpatient hospice capacity or to increase the applicant's inpatient bed capacity.

CRITERION:

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 a need for the proposed project.

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 health care facility. 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.

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

The Commission shall consider the alternative approaches to meeting the need identified for the project that were considered by the applicant in planning the project and the basis for the applicant's choice of the project among considered alternatives. In a comparative review of applications within the same review cycle, the Commission shall compare the costs and the likely effectiveness of alternative projects in meeting identified needs, improving the availability and accessibility of care, and improving the quality of care.

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.

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

Project Financial Feasibility and Facility or Program Viability. The Commission shall consider the availability of resources necessary to implement the project and the availability of revenue sources and demand for the proposed services adequate to ensure ongoing viability and sustainability of the facility to be established or modified or the service to be introduced or expanded.

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 health care facility 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).

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

COMAR 10.24.01.08G(3)(e) Compliance with Terms and Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous CON granted to the applicant.

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.

10.24.01.08G(3)(f). Impact on Existing Providers.

Project Impact. The Commission shall consider the impact of the proposed project on the costs and charges of existing providers of the facilities and services included in the project and on access to those facilities and services in the service area of the project.

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 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 health care facility, provide a summary description of the impact of the proposed project on costs and charges of the applicant's health care facility, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

10.24.01.08G(3)(g) Health Equity. The Commission shall consider how a proposed project will address health care disparities in availability, accessibility, and quality of care among different populations within the service area. The Commission shall consider how social determinants of health within the service area of the proposed project create disparities in the delivery of health care.

INSTRUCTIONS: In evaluating proposed projects for health equity, the Commission will scrutinize the project's impact on health care disparities and social determinants within the service area. Health equity involves the fair distribution of resources and opportunities, ensuring individuals, regardless of background, have the chance to achieve their highest level of health. It further encompasses addressing disparities and systemic barriers that affect different populations.

With health equity in mind, the applicant shall identify the specific medically underserved area(s)/group(s)¹ within the designated service area and outline how the proposed project will address the unique health needs and quality of care for each identified group.

Applicants are expected to furnish a detailed overview of their organization's expertise and experience in health care access and service delivery. Emphasis should be placed on highlighting any relevant background that underscores the organization's commitment to equitable health care. This encompasses efforts to integrate implicit bias and cultural competency training within the health facility and among current staff members.

Please provide a comprehensive account of how the applicant planned with the community during the preparations for this project and how it will continue to engage with the community. Include a description of any specific initiatives and programs aimed at improving community well-being that are relevant to the proposed project. If applicable, the applicant should acknowledge any unintended barriers caused by the project that may have been identified through community discourse and propose initiative-taking solutions to mitigate and rectify potential issues.

10.24.01.08G(3)(h) Character and Competence.

INSTRUCTIONS: In evaluating proposed projects for Character/Competence, the Commission will review the information provided in response to Part III of the application and look for a detailed narrative response highlighting any past issues and how any issues have now been corrected or addressed. If there have not been any past issues please include in your narrative any history that has been a positive reflection of character/competence. The response should include, at minimum:

¹ According to HRSA, medically underserved populations and areas are identified as those which lack access to primary care services. These groups may face economic, cultural, or language barriers to health care. Some examples include: People experiencing homelessness, people who are low-income, people who are eligible for Medicaid, Native Americans and other historically disadvantaged populations of color, migrant farm workers, etc.
(<https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups>)

- names/addresses of all owners and individuals responsible for the proposed project and its implementation. This includes any person with 5% or more ownership interest in the real property, bed rights or operations of the facility
- for each individual identified disclose any involvement in the ownership, development, or management of another health care facility
- for each individual and facility identified disclose if any license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years
- for each individual and facility identified disclose inquiries in the last from 10 years from any federal (CMS) or state authority (OHCQ), or other regulatory body regarding possible non-compliance with any state, or federal 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
- disclose if any owners and individuals responsible for the project have identified above have 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

REMEMBER TO SUBMIT THE COMPANION TABLE SET FEATURING THE PROJECT BUDGET, STATISTICAL PROJECTIONS, REVENUE AND EXPENSE PROJECTIONS, AND WORKFORCE INFORMATION

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identity and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner, or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

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 authorized agent of the applicant for 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.

Signature of Owner or Authorized Agent of the Applicant

Print name and title

Date: _____

Hospice Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE FACILITY TABLE 2B: STATISTICAL
PROJECTIONS – PROPOSED PROJECT TABLE 3: REVENUES AND EXPENSES - ENTIRE
FACILITY TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: MANPOWER INFORMATION

TABLE 1: Project Budget

Instructions: All estimates for 1a- d; 2a- f; and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. Inflation from date of submission of project completion should only be included on the Inflation line 1e. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

| | |
|---|-----------|
| A. USE OF FUNDS | |
| 1. CAPITAL COSTS (if applicable): | |
| a. New Construction | |
| 1) Building | \$ |
| 2) Fixed Equipment (not included in construction) | |
| 3) Architect/Engineering Fees | |
| 4) Permits, (Building, Utilities, Etc.) | |
| a. SUBTOTAL New Construction | \$ |
| b. Renovations | |
| 1) Building | \$ |
| 2) Fixed Equipment (not included in construction) | |
| 3) Architect/Engineering Fees | |
| 4) Permits, (Building, Utilities, Etc.) | |
| b. SUBTOTAL Renovations | \$ |
| c. Other Capital Costs | |
| 1) Movable Equipment | |
| 2) Contingency Allowance | |
| 3) Gross Interest During Construction | |
| 4) Other (Specify) | |
| c. SUBTOTAL Other Capital Cost | \$ |
| TOTAL CURRENT CAPITAL COSTS (sum of a - c) | \$ |
| Non-Current Capital Cost | |
| d. Land Purchase Cost or Value of Donated Land | \$ |
| e. Inflation (state all assumptions, including time period and rate) | \$ |
| TOTAL PROPOSED CAPITAL COSTS (sum of a - e) | \$ |
| 2. FINANCING COST AND OTHER CASH REQUIREMENTS | |
| a. Loan Placement Fees | \$ |
| b. Bond Discount | |
| c. CON Application Assistance | |
| c1. Legal Fees | |
| c2. Other (Specify and add lines as needed) | |
| d. Non-CON Consulting Fees | |
| d1. Legal Fees | |
| d2. Other (Specify and add lines as needed) | |
| e. Debt Service Reserve Fund | |
| f. Other (Specify) | |
| TOTAL (a - e) | \$ |
| 3. WORKING CAPITAL STARTUP COSTS | \$ |
| TOTAL USES OF FUNDS (sum of 1 - 3) | \$ |

| B. SOURCES OF FUNDS FOR PROJECT | |
|--|-----------|
| 1. Cash | |
| 2. Pledges: Gross _____, less allowance for uncollectables _____ = Net | |
| 3. Gifts, bequests | |
| 4. Authorized Bonds | |
| 5. Interest income (gross) | |
| 6. Mortgage | |
| 7. Working capital loans | |
| 8. Grants or Appropriation | |
| a. Federal | |
| b. State | |
| c. Local | |
| 9. Other (Specify) | |
| TOTAL SOURCES OF FUNDS (sum of 1-9) | \$ |
| ANNUAL LEASE COSTS (if applicable) | |
| • Land | |
| • Building | |
| • Moveable equipment | |
| • Other (specify) | |

Instructions: Complete Table 2A for the Entire General Hospice Program, including the proposed project, and **Table 2B** for the proposed project only using the space provided on the following pages. **Only existing facility applicants should complete Table 2A. All Applicants should complete Table 2B. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).**

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE Hospice Program

| CY or FY (circle) | Two Most Current Actual Years | | Projected years – ending with first year at full utilization | | | |
|---------------------------------------|-------------------------------|--|--|------|------|------|
| | | | 20__ | 20__ | 20__ | 20__ |
| Admissions | | | | | | |
| Deaths | | | | | | |
| Non-death discharges | | | | | | |
| Patients served | | | | | | |
| Patient days | | | | | | |
| Average length of stay | | | | | | |
| Average daily hospice census | | | | | | |
| Visits by discipline | | | | | | |
| Skilled nursing | | | | | | |
| Social work | | | | | | |
| Hospice aides | | | | | | |
| Physicians - paid | | | | | | |
| Physicians - volunteer | | | | | | |
| Chaplain | | | | | | |
| Other clinical | | | | | | |
| Licensed beds | | | | | | |
| Number of licensed GIP beds | | | | | | |
| Number of licensed Hospice House beds | | | | | | |
| Occupancy % | | | | | | |
| GIP (inpatient unit) | | | | | | |
| Hospice House | | | | | | |

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

| CY or FY (circle) | Projected years – ending with first year at full utilization | | | |
|---------------------------------------|--|------|------|------|
| | 20__ | 20__ | 20__ | 20__ |
| Admissions | | | | |
| Deaths | | | | |
| Non-death discharges | | | | |
| Patients served | | | | |
| Patient days | | | | |
| Average length of stay | | | | |
| Average daily hospice census | | | | |
| Visits by discipline | | | | |
| Skilled nursing | | | | |
| Social work | | | | |
| Hospice aides | | | | |
| Physicians - paid | | | | |
| Physicians - volunteer | | | | |
| Chaplain | | | | |
| Other clinical | | | | |
| Licensed beds | | | | |
| Number of licensed GIP beds | | | | |
| Number of licensed Hospice House beds | | | | |
| Occupancy % | | | | |
| GIP (inpatient unit) | | | | |
| Hospice House | | | | |

TABLE 3: REVENUES AND EXPENSES - ENTIRE Hospice Program (including proposed project)

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

| CY or FY (Circle) | Two Most Recent Years -- Actual | | Current Year Projected | Projected Years (ending with first full year at full utilization) | | | |
|--|---------------------------------|--------|------------------------|---|--------|--------|---------|
| | 20____ | 20____ | 20____ | 20____ | 20____ | 20____ | 20-____ |
| 1. Revenue | | | | | | | |
| a. Inpatient services | | | | | | | |
| b. Hospice house services | | | | | | | |
| c. Home care services | | | | | | | |
| d. Gross Patient Service Revenue | | | | | | | |
| e. Allowance for Bad Debt | | | | | | | |
| f. Contractual Allowance | | | | | | | |
| g. Charity Care | | | | | | | |
| h. Net Patient Services Revenue | | | | | | | |
| i. Other Operating Revenues (Specify) | | | | | | | |
| j. Net Operating Revenue | | | | | | | |
| 2. Expenses | | | | | | | |
| a. Salaries, Wages, and Professional Fees, (including fringe benefits) | | | | | | | |
| b. Contractual Services | | | | | | | |
| c. Interest on Current Debt | | | | | | | |
| d. Interest on Project Debt | | | | | | | |
| e. Current Depreciation | | | | | | | |
| f. Project Depreciation | | | | | | | |
| g. Current Amortization | | | | | | | |
| h. Project Amortization | | | | | | | |
| i. Supplies | | | | | | | |
| j. Other Expenses (Specify) | | | | | | | |
| k. Total Operating Expenses | | | | | | | |
| 3. Income | | | | | | | |
| a. Income from Operation | | | | | | | |
| b. Non-Operating Income | | | | | | | |
| c. Subtotal | | | | | | | |

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

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

| CY or FY (Circle) | Projected Years (ending with first full year at full utilization) | | | |
|---|--|--------|--------|--------|
| | 20____ | 20____ | 20____ | 20____ |
| 1. Revenue | | | | |
| a. Inpatient services | | | | |
| b. Hospice House services | | | | |
| c. Home care services | | | | |
| d. Gross Patient Service Revenue | | | | |
| e. Allowance for Bad Debt | | | | |
| f. Contractual Allowance | | | | |
| g. Charity Care | | | | |
| h. Net Patient Services Revenue | | | | |
| i. Other Operating Revenues (Specify) | | | | |
| j. Net Operating Revenue | | | | |
| 2. Expenses | | | | |
| a. Salaries, Wages, and Professional Fees, (including fringe benefits) | | | | |
| b. Contractual Services | | | | |
| c. Interest on Current Debt | | | | |
| d. Interest on Project Debt | | | | |
| e. Current Depreciation | | | | |
| f. Project Depreciation | | | | |
| g. Current Amortization | | | | |
| h. Project Amortization | | | | |
| i. Supplies | | | | |
| j. Other Expenses (Specify) | | | | |
| k. Total Operating Expenses | | | | |
| 3. Income | | | | |
| a. Income from Operation | | | | |
| b. Non-Operating Income | | | | |
| c. Subtotal | | | | |
| d. Income Taxes | | | | |
| e. Net Income (Loss) | | | | |

| Table 4 Cont. | Projected Years (ending with first full year at full utilization) | | | | |
|--|--|--------|--------|--------|--------|
| | CY or FY (Circle) | 20____ | 20____ | 20____ | 20____ |
| 4. Patient Mix | | | | | |
| A. As Percent of Total Revenue | | | | | |
| 1. Medicare | | | | | |
| 2. Medicaid | | | | | |
| 3. Blue Cross | | | | | |
| 4. Other Commercial Insurance | | | | | |
| 6. Other (Specify) | | | | | |
| 7. TOTAL | 100% | 100% | 100% | 100% | 100% |
| B. As Percent of Patient Days/Visits/Procedures (as applicable) | | | | | |
| 1. Medicare | | | | | |
| 2. Medicaid | | | | | |
| 3. Blue Cross | | | | | |
| 4. Other Commercial Insurance | | | | | |
| 5. Self-Pay | | | | | |
| 6. Other (Specify) | | | | | |
| 7. TOTAL | 100% | 100% | 100% | 100% | 100% |



TABLE 5. MANPOWER INFORMATION

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

| Position Title | Current No. FTEs | Change in FTEs (+/-) | Average Salary | Employee/ Contractual | TOTAL COST |
|-----------------------|------------------|----------------------|----------------|-----------------------|------------|
| Administration | | | | | |
| Administration | | | | | |
| Direct Care | | | | | |
| Nursing | | | | | |
| Social work/services | | | | | |
| Hospice aides | | | | | |
| Physicians-paid | | | | | |
| Physicians- volunteer | | | | | |
| Chaplains | | | | | |
| Bereavement staff | | | | | |
| Other clinical | | | | | |
| Support | | | | | |
| Other support | | | | | |
| | | | | Benefits* | _____ |
| | | | | TOTAL | _____ |

* Indicate method of calculating benefits cost
