

PART I: PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. Identify the relationship between the following entities: Columbia Vantage House Corp., Vantage House LLC, and Life Care Services, LLC (LCS). Specifically, identify how they are related, including any common ownership.

The real property comprising the Vantage Point facility and the land on which it is located is owned by Vantage House LLC. Columbia Vantage House Corporation owns all the interests in Vantage House LLC, and operates under a lease agreement with Vantage House LLC. Columbia Vantage House Corporation entered into a management agreement with an independent management firm, Life Care Services LLC to provide a full range of day-to-day management services. Life Care Services LLC does not share any common ownership with Columbia Vantage House Corporation nor Vantage House LLC. It does not own the property or hold any licenses on behalf of Columbia Vantage House Corporation nor Vantage House LLC

2. Describe in detail the services provided by LCS.

Life Care Services LLC provides operational, financial, and managerial oversight of the community, including recommended policies and procedures, marketing support, clinical activities/support, IT services/systems, HR services/systems, compliance support with respect to federal and state statutes and regulations (licensing), and accounting/financial services. Life Care Services also employs the Executive Director and Health Care Administrator, who have oversight over the operations of the community.

3. Will all beds be dual certified for Medicare and Medicaid patients?

Yes, all CCF beds in the facility will be dually certified.

4. Regarding the patient rooms:

- a. Identify which rooms are semi-private and private on the drawing.**
- b. Provide a table listing the dimensions of each patient room.**

See table immediately below, which identifies private/semi-private rooms as well as SF.

Room#	Private/Semi Private	Sq. Ft.
301A	Semi	267
302	Private	242
303A	Semi	267
304	Private	242
305	Private	267
306	Private	242
307	Private	267
308	Private	242
309A	Semi	267
310	Private	242
311A	Semi	267

Room#	Private/Semi Private	Sq. Ft.
312	Private	242
313A	Semi	267
314	Private	242
315A	Semi	267
317	Private	267
337A	Semi	267
338	Private	242
339A	Semi	267
340	Private	242
341A	Semi	267
342	Private	242
343A	Semi	267
344A	Semi	242
345	Private	267
346	Private	242
347A	Semi	267
348A	Semi	242
349A	Semi	267
350	Private	242

PART II TABLE SET QUESTIONS

5. Explain and justify the assumptions underlying Tables D (entire facility), E (new facility), F (revenues and expenses), and G (new facility revenues and expenses). Include assumptions for admissions, length of stay, payor mix, payor rates, and expense lines, addressing both CCRC and public patients.

The table below explains the assumptions underlying the Tables in RVP’s CON application.

Admissions	#	Medicare	HMO	Medicaid	Private Pay	Life-Care Perm	Life-Care Temp
Public	65	60	N/A	5	N/A	N/A	N/A
CCRC	65	36	N/A	N/A	10	4	15
LOS							
LOS	#	Medicare	HMO	Medicaid	Private Pay	Life-Care Perm	Life-Care Temp
Public	65	30 days		365 days	N/A	N/A	N/A
CCRC	65	30 days			183 days	730 days	37 days
Payer Mix							
Payer Mix	Census	Medicare	HMO	Medicaid	Private Pay	Life-Care Perm	Life-Care Temp
Public	10	30%	20%	50%	N/A	N/A	N/A
CCRC	17.5	17%	0	0	29%	46%	8%

Payer Rates		Medicare	HMO	Medicaid	Private Pay	Life-Care Perm	Life-Care Temp
		\$598/day	\$319/Day	\$205/day	\$409/\$475 day Semi private/Private	\$409/\$475 day Semi private/Private (Before lifecare discount)	\$0 (Free Days)

Expense assumptions are based on current costs per resident day for non-salary related expenses. Salary expenses increased due to increased census in the CCF.

- 6. Exhibit 17, the audited financial statements, has some inconsistencies with Table F, (revenues and expenses). The net operating revenue, total operating expenses, operating income and non-operating income under table F do not match the statement of operations published in the audited financial statements. Provide an explanation for the identified inconsistencies.**

Exhibit 17 – Table F has been updated to align with the audit report (EXHIBIT 28: REVISED TABLES PACKAGE).

The initial discrepancy noted by staff was due to several factors:

- LCS staff used unaudited financial reports to create these tables, leading to some minor discrepancies; the Tables Package now reflects audited results.
- LCS staff also prepared the application tables using different expense groupings than those that were used in the audit report; those expense groupings have been aligned.
- There was a typo in the 2023 Salaries and wages line that has been corrected.
- Revenue from Earned Entrance Fees and contributions were accounted for differently in the Tables Package than they are in the audited financials. Those elements are now aligned, and appear as Other Operating Income.

- 7. The projections in table H (workforce) are not consistent with salary and wage expenses provided in uninflated projections in tables F and G. Explain these variances and/or rework the tables.**

- a. Current Year Total Cost column, at \$8.043 million, is expected correspond with Table F, current year fiscal year (FY) 2025 column, at \$9.267 million, but it does not.**

Table H asks for average salary per FTE, while Tables F & G ask for Salaries & Wages (including benefits). They differ because the applicant has not included benefits for Table H as those are blacked out in row 36. Benefits/Taxes are assumed at 20% in Table F.

- b. Total Cost column (under project changes as a result of the proposed project), at \$591 thousand for the new facility, is expected to correspond with Table G FY 2032 at \$770 thousand.**

Table H asks for average salary per FTE, while Table G asks for Salaries & Wages (including benefits). The applicant has not included benefits for Table H, as that field (Row 36) is blacked out. Benefits/Taxes are assumed at 30%, as Health Center staff are more

likely to carry insurance coverage, thus the applicant assumes a higher % of wages for benefits for those new employees.

- c. Likewise, the Total Cost column (under project entire facility through last year of projection), at \$8.634 million for the entire facility, is expected to correspond with Table F, final year of projection FY 2032 (\$10.038 million).**

Table H is asking for average salary per FTE vs F & G are requesting Salaries & Wages (including benefits). We have not included benefits for table H as those are blacked out in row 36. Benefits/Taxes is 20% of wages.

- 8. Explain whether the workforce projections on Table H include benefits. If benefits are not included, state the percentage for reconciliation with revenue and expenses Table F and G.**

As stated above, Table H does not include any benefit costs, as explained in the preceding response. We have added the % to the corresponding question above.

- 9. Regarding Table F, explain why the salaries and wages (including benefits) and supplies expense lines show a downward trend from FY 2023 to FY 2025, despite increased occupancy during the same period. Typically, healthcare organizations anticipate growth in these areas. Additionally, these same line items reflect an increase from FY 2023 to FY 2024 on page 24 of the audited financial statements (Exhibit 17). Clarify this discrepancy.**

Table F has been restated based on audited financial statements and correction of a typo. Explanations follow:

- a. A typo in the 2023 Salaries & Wages has been corrected.
- b. In the initial submission the Salaries/Wages of LCS staff was accounted for in the 'Other' bucket. It has now been booked as Salaries/Wages.
- c. Supply expenses decrease from 2023 as the effects of COVID precautions eased. Specifically, cost for Personal Protective Equipment and Food and Beverage costs decreased (during COVID the dining area was closed and meals were served in take out containers).

- 10. Regarding Table F, explain why depreciation increases between FY 2023 – FY 2024, and then from FY 2025 and beyond. Commission staff expect that the depreciation (current depreciation) normally falls with time as assets become fully depreciated.**

Depreciation is increasing due to a number of recent capital expenditures related to reinvestment into the community. RVP is embarked upon a long term asset replacement plan that will continue ongoing investment into the community. This is why depreciation will not materially decrease over the projected time period.

- 11. In Table I (staffing patterns), the Excel cells E-11-12 and cells J-11-12 are blank. Provide a revised table I with the number of licensed beds at project completion and the calculated hours of bedside care per licensed bed per day.**

Table I has been updated to show the number of licensed beds and hours per licensed bed. Note that RVP staffs based on census level, rather than based on the number of licensed beds; evaluating the appropriateness of staffing levels can best be understood by analyzing staff levels per patient-day rather than staffing levels per licensed bed.

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

12. Indicate if the Executive Director, Pierce Carey has any relationship, ownership, or management of/to another health care facility and if so, what this relationship is.

Executive Director, Pierce Carey, does not have any relationship, ownership or management responsibility of any other health care facility.

PART IV – CONSISTENCY WITH GENERAL REVIEW CRITERIA

THE STATE HEALTH PLAN: NURSING HOME STANDARDS

Bed Need and Average Annual Occupancy

13. Who is the target population for the proposed project?

The target population of this project is all seniors over the age of 65 needing short-term rehabilitation and long-term care in the greater Howard County area.

Community Based Services

14. How will RVP disseminate information about the Money Follows the Person program to its residents? Provide a copy of the information that will be disseminated.

As stated in our application, RVP maintains strong relationships with home health and hospice providers, enabling RVP to guide clients to the level of care best suited to their situation. These long-standing relationships with community-based organizations enable us to provide clients with a full array of long-term care options and seamless transitions to and from comprehensive care.

We commit to utilizing the *Money Follows the Person Program*, and have created an information piece to be distributed to all clients and/or responsible parties considering admission to long term care (Exhibit 21).

15. Exhibit 10 informs “newly admitted residents” about community- based services. Does RVP have a similar notification for prospective residents (i.e., to give them an alternative to RVP)?

See the revision of this information piece, which will be distributed to “*prospective and newly admitted residents.*” (Exh. 22)

16. How does/will RVP minimize nursing home length of stay for residents?

RVP starts the discharge-planning process upon admission. RVP and its therapy vendor [Aegis Therapies](#) are committed to ensuring that residents requiring short-term rehabilitation receive timely and effective care, with the goal of returning them to the appropriate setting as efficiently as possible. This commitment includes hosting daily clinical meetings to review each resident’s needs and progress, and working closely with residents and/or their Responsible Parties to support a safe and timely discharge. A description of that process follows:

The discharge process for residents is a coordinated effort that ensures a safe and smooth transition to the next level of care or home setting. Once a discharge is planned—either at the request of the resident/family or based on changes in care needs—our interdisciplinary team initiates a thorough review. This includes a physician evaluation, updated care assessments, medication reconciliation, and coordination with external providers or home health services.

Families are engaged early in the process to ensure proper support, equipment, and follow-up care are arranged. Social Services plays a key role in discharge planning, including scheduling transportation and facilitating communication with outside agencies. A discharge summary is provided, and the resident’s medical records and personal belongings are reviewed and released accordingly.

Our goal is to ensure each resident’s safety, dignity, and continuity of care throughout the discharge process.

17. Provide the documentation in the discharge plan policy (Exhibit 12) that references a 24-month plan with checks at 6-month intervals.

See Exhibit 23, *Care Plans, Comprehensive Person-Centered*. Note that the quarterly care plan process includes goals related to discharge, and states:

- 14. *The interdisciplinary team must review and update the care plan:*
 - a. *when there has been a significant change in the resident’s condition;*
 - b. *when the desired outcome is not met;*
 - c. *when the resident has been readmitted to the facility from a hospital stay;*
and
 - d. *at least quarterly, in conjunction with the required quarterly MDS assessment.*

Appropriate Living Environment

18. Provide the plan of correction developed following the 12/13/2024 survey citation regarding: (a) failure to provide and implement an infection prevention and control

program; (b) failure to properly sanitize during a med pass; and (c) improperly discarding syringes into the sharps container.

See a copy of the plan of correction, attached as Exhibit 24.

19. How does RVP staff monitor residents with special needs—particularly those with dementia or other neurodegenerative disorders such as Alzheimer’s and Parkinson’s? In particular, how does RVP staff work to comply with and implement the FGI Guidelines 2.1-2.1.2.3(2)(a) on elopement prevention and A2.1-2.1.2.3(3)(b)(ii) on special room design for residents with a dementia care diagnosis?

RVP is proud to be a Gold-Level Certified Heartfelt Connections® community. This program provides specialized training for staff to support residents with neurocognitive disorders, including Alzheimer’s and related dementias.

Heartfelt Connections – A Memory Care Program®, is an exclusive LCS Signature Experience, and is a nationally-recognized program delivering personalized care focused on each resident’s remaining abilities, helping them live with purpose and dignity. *Heartfelt Connections* focuses on the resident and their abilities. Memories fade, but past relationships and experiences continue to shape the lives of residents every day. *Heartfelt Connections* uses customized reminiscence tools to help loved ones capture a lasting legacy of details about each resident’s life — family, friends, career, hobbies, likes and dislikes.

The insights gained from each life story are the basis of individualized programming for every resident. Customized activities are designed to promote physical and emotional well-being and prolong daily functioning. These activities also help residents maintain a sense of purpose, satisfaction, dignity and quality of life.

Additionally, our Skilled Nursing Facility (SNF) is equipped with a WanderGuard® system. Residents identified as an elopement risk may be fitted with a WanderGuard device that alerts staff if exit-seeking behavior occurs. This proactive system helps ensure safety while allowing residents to ambulate freely and appropriately within the unit.

We would also note that RVP includes a Memory Care Unit as part of its Assisted Living services.

20. Provide the length of the grab bars that are currently in place at the rear and sides of the toilets. Provide the length of the grab bars in the tub that is on the control wall and the length of the supplemental grab bar.

The rear and side grab bars are 18 inches and 24 inches long, respectively.

21. Exhibit 10 includes a letter stating that RVP offers various therapy services (i.e., physical, speech, and occupational). It appears this may only apply to the home health setting upon discharge. Explain where the nursing home patients will receive therapy in the facility. Include the dimensions of any therapy rooms at the facility.

Therapy services, including PT, OT, and ST are currently provided to residents of the community on both an inpatient and outpatient basis. RVP currently offers inpatient rehabilitation to all residents of our skilled nursing facility, a service that would of course also be available to “public patients” should we be authorized to serve them..

These services are provided on the first floor of the skilled nursing facility. An illustration of the space is shown on Exhibit 25. Dimensions are as follows:

- PT/OT: 1308 SF
- Cardio/Aerobics: 1280 SF

22. Provide more information on how RVP plans to provide the option for the public nursing home residents to maximize their opportunities for ambulation and self-care, socialization, and independence.

At RVP, we are committed to promoting resident independence by providing opportunities for mobility, active participation in care, and social engagement. Our robust activities calendar (attached as Exhibit 26), person-centered care philosophy, and dedicated team work together to create a supportive, home-like environment for all residents.

Quality

23. RVP was below the Maryland average for residents receiving the pneumonia vaccine and below the Maryland average for staff receiving the COVID and flu vaccines. What steps have been taken to improve this performance?

Residences at Vantage Point continues to provide ongoing education regarding the importance of vaccinations for our community, and hosts regular on-site vaccine clinics where staff and residents are able to conveniently participate. Vaccination clinics are synchronized to the release dates of vaccine updates. We actively encourage staff and residents to receive vaccines on a routine basis, in consultation with their medical providers.

Although the proportion of RVP residents receiving the pneumonia vaccine was below the Maryland average, the rates are nearly the same for all practical purposes: almost 75% compared to a state average of 78.2%; meanwhile our application shows a resident COVID vaccination rate of 88.9% compared to a state average of 44.6%, and a resident flu vaccination rate of almost 93% compared to a statewide average of about half that (44.6%).

However, as MHCC staff points out, our staff vaccination rates have been lower than we would like, and RVP commits to seeking out and evaluating the methods of other peers that have shown greater success in gaining and maintaining high vaccination rates.

24. What steps has RVP taken to improve its response rate for the MHCC *Family Experience of Care Survey*?

This question is in reference to the part of the standard which asks the applicant to “**report its rating of overall care and percent satisfied for the most recent three years on the MHCC**

Family Experience of Care Survey, reporting on any trends in the results,” and to “document efforts to improve the facility’s rating” if the overall rating is lower than 7.0.

Our initial response stated that RVP has no rating because it was excluded from the survey by the surveyor due to an insufficient number of residents and/or their representatives completing the survey to meet the eligibility threshold for reporting. We are hopeful that with an increased number of beds, there will be a sufficient number of respondents for RVP’s survey results to be reported.

RVP has not received published results for the most recent three-year period, and so is unable to report trends or provide average ratings for overall care, and has no indication where improvement might be needed.

Vantage Point participates in the Maryland Health Care Commission (MHCC) Family Experience of Care Survey annually. This survey is designed and conducted by an independent third-party vendor to ensure objectivity and consistency across all participating facilities. RVP is not in control of the survey process, which is the responsibility of the third party engaged by MHCC. Vantage Point submits names, addresses, and email addresses to MHCC, and the survey agency that MHCC engages uses that information to contact residents and their representatives. We understand that the vendor’s method to improve the response rate to its survey is uniformly applied throughout the survey process for all nursing homes, and includes follow-up requests being made to prospective respondents.

Vantage Point remains fully committed to the MHCC survey process and will continue to partner in this important program, as well as putting emphasis on educating residents and families regarding the completion of the MHCC Family Experience of Care Survey.

Quality Assurance

25. Exhibit 15 includes performance improvement projects (PIP) as an agenda item. MHCC would like to see the PIP related to the infection control citation.

See a copy of the plan of correction, attached as Exhibit 24.

26. Your response states that the Quality Assurance committee meets “quarterly” but monthly meeting dates are shown for the past three years. Clarify the frequency of this meeting.

These meetings occur monthly.

Collaborative Relationships

27. The response to question 9a on page 31 does not demonstrate evidence of relationships with BrightStar, Harmony Hall, or Copper Ridge. RVP does not indicate that it has any relationships with adult day care programs or other community providers in the long-term care continuum. Provide documentation of these relationships.

RVP has a strong history of collaboration with Winter Growth in Columbia to foster supportive relationships with adult day care providers. This includes:

- Current RVP residents participating in Winter Growth’s Adult Day Program;
- At times, though not currently, there have been overlapping board members between our organizations;
- Professional connections between staff teams.

Winter Growth’s proximity to Vantage Point supports a mutually beneficial partnership in serving older adults in Howard County.

Staff guidance directs an applicant to “...document link to at least one of EACH of the type of provider mentioned in the Standard via letter (new entrants) or copy of a contract (existing) with the community provider.” As required by the standard, RVP’s application included documentation for all delineated types of providers except for adult day care.¹ Exhibit 27 now provides a letter from Winter Growth, an Adult Day Care provider. We have updated the relevant table accordingly.

Provider Class	Provider	Nature of Relationship	Documentation of Relationship
Hospitals	Howard County General Hospital	Referring hospital provider (contract provided)	Contract (see Exh. 16)
Hospice Programs	Gilchrist	In-home, or in-patient hospice provider (contract provided)	Contract (see Exh. 16) Letter (see Exh. 9)
	Accent Care (formerly Seasons)	In-home hospice care (contract provided)	Contract (see Exh. 16)
Home Health Agencies	Bayada	Home Health referral provider	Letter expressing working relationship (see Exh. 16)
	BrightStar Care	Home health and home care referral provider	
Assisted Living Facilities	Morning Side House	Assisted Living provider	Letter (see Exh.9)
	Harmony Hall	Assisted Living provider	
	Copper Ridge	Assisted Living provider	
Adult Day Care	Winter Growth	Adult Day Provider	Letter expressing working relationship (Exh. 27)

28. According to the Medicare Care Compare data on June 24, 2025, the facility received an overall rating of two out of five stars for long-term resident care, with several substandard metrics in comparison to the national average. These are:

a. Hospitalizations (2.36% compared to 1.84%)

¹ (9) Collaborative Relationships.

(a) An applicant shall document its relationships with hospitals, hospice programs, home health agencies, assisted living providers, Adult Evaluation and Review Services, adult day care programs, and other community providers in the long-term care continuum. This may include contracts, letters or other relevant documentation.

- b. Residents receiving antipsychotics (33.3% compared to 14.6%)
- c. One or more falls with major injury (7.9% compared to 3.3%)
- d. Pressure ulcers (13.1% compared to 5.5%)
- e. UTIs (4.9% compared to 1.9%)
- f. Resident receiving pneumonia vaccine (88.9% compared to 93.4%).

Describe any actions RVP plans to take to improve these measures.

RVP continuously monitors quality measures and provides regular updates to the QA Committee on any identified deficiencies. Many of the flagged Quality Measures are influenced by our small census, which can disproportionately skew percentages when even one resident triggers a measure. For example, a single fall resulting in a major injury (1 numerator) among 14 residents (denominator) results in a 7.1% rate despite the low absolute number of such events. While not perfect, the absolute number of such incidents remains low and demonstrates a commitment to quality.

Persistent quality issues would be reflected in the annual CMS survey. However, RVP’s most recent survey (December) resulted in only 6 deficiencies, compared to the U.S. average of 9.5 and Maryland’s average of 19.3—a strong indicator of our ongoing commitment to quality care.

ADDITIONAL APPLICATION CRITERIA:

NEED

29. Provide population projections for adults age 65-69.

The table below has been expanded (from initial CON application submission) to include the Howard County population projections for adults age 65-69.

	65-69	70-74	75-79	80-84	85+	Total
2020	16,841	13,312	9,204	5,493	4,847	49,697
2025	19,126	15,175	12,329	7,786	6,047	60,463
2030	21,098	17,257	14,083	10,423	8,226	71,087
2035	19,374	19,085	16,048	11,954	11,343	77,803

Source: Maryland Department of Planning Total Population Projections https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx

ALTERNATIVES TO THE PROJECT

30. Provide the occupancy for the 44 skilled nursing beds between calendar year 2014 and 2023, for comparison to the information supplied in the table for 2024 through 2033. Maximum beds should be stated as whole numbers.

Occupancy for 2014 – 2023 provided below.

	Units Occupied	Occupancy %
2014	23	52%

	Units Occupied	Occupancy %
2015	20	46%
2016	20	46%
2017	25	57%
2018	16	36%
2019	15	34%
2020	7	16%
2021	10	23%
2022	12	24%
2023	19	43%

31. Related to planning the project, what factors were considered in the decision to open the existing nursing home beds to the Medicaid population, for example, reimbursement rates, cultural differences, mental health needs, disparities, etc.?

This initiative grew out of discussion with our residents and Board. The main factors that emerged were:

- A recognition of the need for additional revenue sources. RVP has excess CCF capacity, but without an open Certificate of Need (CON), we are unable to attract and serve residents in Howard County who are not already part of our community.
- Meetings with members of the Howard County Delegation highlighted the need for more nursing beds in the county, an opinion that we found to be supported by MHCC’s bed need projections.
- As a non-religious, not-for-profit organization, our sole mission is to serve older adults in Howard County. Broadening our resident base supports and advances this mission.

PROJECT FINANCIAL FEASIBILITY AND FACILITY OR PROGRAM VIABILITY

32. The audited financial statements show no excess of revenue over expenses—excluding other non-operating income—for the audited financial years 2023, 2024, the current year 2025, as well as projected years. Considering this, why do you think the opening of 13 beds to the general public represents a strategic opportunity to strengthen RVP’s financial outlook and how do you think it would support ongoing viability or sustainability of the facility?

RVP has operated successfully since October 1990 and remains in a strong financial position. As of the June 2024 audit report, the organization reported over \$11.3 million in working capital and maintained 287 days of cash on hand, underscoring its robust liquidity and prudent fiscal management.

More recently, the community has been focused on operational efficiencies and growing Independent Living (IL) occupancy to decrease that shortfall and increase cash flow from the nonrefundable portion of the entrance fees paid by new IL residents.²

² That is, the Return Of Capital (ROC) amount has been reduced and RVP retains more of the Entry Fees.

The applicant believes that *the opening of 13 beds to the general public represents a strategic opportunity to strengthen RVP's financial outlook* because it requires no financial investment from RVP and while enhancing the organization's financial performance by allowing it to spread fixed costs over a larger base. We project that utilization of RVP's 44 nursing home beds would improve by more than 50% (see Table D in the Tables Package) which will generate a significant new revenue stream.

Specifically, allocating 13 beds for public use is projected to increase net operating revenue by over \$1.24 million, while incurring less than \$1.08 million in additional operating costs (Table G). This additional margin from the "public beds," combined with and ongoing efforts focused on efficiencies, position RVP for profitability, with projections indicating sustained positive margins moving forward. Combined with other efforts to increase cash flow, this profitability will allow the community to reinvest in the physical plant, service the debt, and slightly grow cash to prepare for the future.

As is typical for Continuing Care Retirement Communities (CCRCs), RVP's financial resilience is supported by revenue from the turnover of independent living units. Note also that the reported operating losses were exacerbated by non-cash expenses such as depreciation and amortization, which do not impact cash flow.

In summary, RVP is on a solid financial footing, and this project represents a strategic opportunity to further strengthen its financial outlook. The initiative will enhance operational efficiency and the long-term sustainability of this vital community resource.

33. Per review of Table F, RVP as an organization (entire facility) appears to have an average cost to revenue ratio (operating expenses over operating revenues) of 113% from fiscal year 2023 to 2032, which means the expenses are higher than revenues. Staff recognize that cash-basis operating income (adding back depreciation and amortization to operating income) yields a better margin of 8% (FY 2023), 17% (FY 2024), and 15% (FY2025 and beyond). Provide the cost-optimization or cost-effectiveness measures being considered to sustain future operations of the facility.

RVP has recently placed more emphasis on working with department heads on cost-optimization. Some recent initiatives include:

- a. Installation of a new EHR to improve staffing efficiency;
- b. Engaging a new therapy vendor at lower cost;
- c. Ensuring that all department heads are versed in and utilizing expense-tracking tools;
- d. Better leveraging our Group Purchasing Organization to ensure RVP takes advantage of the best available pricing.

34. Per review of Table F, the non-operating income does not appear to be sustaining the overall profitability for RVP. FY 2023 and FY 2024 generate losses for the organization, despite having non-operating income of \$1.824M and \$2.219M, respectively. Given the unreliable nature of investment portfolios and their exposure to market risks, how do you expect this income to generate positive returns from FY 2025 and beyond?

Table F has been updated to align with Audit report. The Earned Entrance fees are now included in Other Operating Income.

Regarding the investment portfolio the board utilizes a 85/15 split in the portfolio of Bonds/equity to minimize the risk allocation. The community has also been progressing towards lower Return Of Capital (ROC) contracts that will retain more of the Entry Fees, which will lead to greater cash flow in the future. The deferred revenue from entrance fees has increased \$4.9M over the last 5 years which will allow RVP to capture more cash flow in the future as IL units turn over.

HEALTH EQUITY

35. What community input was sought by RVP regarding the project? What was the community response/feedback?

RVP routinely engages with leadership from the Howard County Delegation. Through these discussions, it became clear that as Maryland's population ages, the demand for high-quality health services continues to grow. This is supported by MHCC's bed need projections for Howard County.

Local officials have noted increased wait times for hospital discharge to post-acute care and voiced concerns from constituents. With our 5-Star SNF, RVP is well-positioned to help meet this growing need and is proud to be part of the solution.

36. The instructions state that “the applicant shall identify the specific medically underserved area(s)/group(s)³ within the designated service area.” Explain how RVP plans to recruit and enroll Medicaid and other underserved populations ages 65 and over in the Howard County service area?

If awarded the CON beds, RVP's Social Worker and Outreach & Admissions Coordinator will initiate outreach to local hospitals, home health agencies, and other providers to inform them of our expanded ability to accept Medicaid residents. This proactive engagement will help ensure the success of the project and further our mission of serving seniors in Howard County.

37. Describe the barriers to nursing home care for residents of Howard County, if any. State any proactive solutions that RVP has developed to reduce these barriers to access.

Current barriers to accessing nursing home care include a shortage of readily available beds.

38. Does the annual training provided include information on implicit bias? If not, how does RVP plan to ensure that all staff will receive implicit bias training?

³ 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://bhwh.hrsa.gov/workforce-shortage-areas/shortage-designation#mups>)

RVP has partnered with Relias Learning to offer staff access to an online training platform, which includes relevant courses tailored to their roles. One such course that fulfills the implicit bias training requirement is outlined below:

Relias Learning	1393061	REL-ALL-0-IBHC	Implicit Bias in Healthcare	<p>Recent movement toward diversity, equity, and inclusion (DEI) is encouraging for historically overlooked individuals. Diversity and inclusivity bring a variety of frequently ignored perspectives and experiences, but it has also uncovered the depth of implicit biases.</p> <p>This course will present the impact of implicit biases and other forms of discrimination on the provision of healthcare, as well as best practices to reduce implicit bias and the means to become a DEI ally.</p> <p>The goal of this course is to provide healthcare employees with training about implicit bias in healthcare.</p>	Online Course	1.5
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CHARACTER AND COMPETENCE

- 39. Describe the character and competence of the LCS leadership, and how that will assist RVP maintain its own character and competence.**
- 40. “Ownership interest” means an owner, former owner, member of senior management or management organization, or current or former owner or senior manager of any related or affiliated entity during the past three years. If there have not been any past negative issues, please include in your narrative any history that has been a positive reflection of the character and competence for both Pierce Carey, Executive Director, and Alexis Hitchcock, Administrator, in senior management.**

Questions 39 and 40 essentially address the same issue, and our response applies to both.

The “Character and Competence” general review criterion requires the Commission to **“assess the character and competence of an applicant [RVP] based upon experience and past performance, including any records of violation in operating a health care service or facility.”**

In Part III we have attested that *“there have not been any past negative issues”* concerning the facility or management. The information and documentation provided in our CON application demonstrates that RVP has achieved recognition as a CMS 5-Star rated facility, reflecting a continuing excellence in performance and regulatory compliance, attributable to the combined efforts of the facility staff, leadership, and Board over many years.

To reiterate:

- RVP is a CMS 5-Star rated facility, and has a longstanding history of excellence in meeting state and federal standards;
- The facility has had no adverse findings, guilty pleas, or citations from state or federal programs;
- Our leadership, including board members, has made Residences at Vantage Point a cornerstone of aging services in Columbia and Howard County for 35 years, working collegially with organizations and agencies that serve elderly and/or infirm populations. Members of our leadership team and Board of Directors have volunteered their time to serve and lead these organizations throughout our history.

We submit that this information speaks for itself and provides what the Commission requires to be able to make a determination of RVP's compliance with this review criterion.

List of Exhibits

21. Community Based Options and *Money Follows the Person* Program
22. Community-Based Services Guide
23. Care Plans, Comprehensive Person-Centered
24. Plan of Correction
25. Floor Plan, Therapy Space
26. Activities Calendar
27. Letter from *Winter Growth*
28. Revised Tables Package
29. Affirmations

EXHIBIT 21



The Home and Community-Based Options Waiver

The Home and Community-Based Options Waiver provides services for older adults and individuals with physical disabilities in order for them to live at home or an assisted living facility instead of a nursing facility. The Maryland Department of Health administers this waiver.

Services that may be provided include:

- Assisted living services (not including room and board)
- Behavior consultation services
- Case management
- Dietitian and nutritionist services
- Medical day care
- Senior Center Plus
- All other standard Medicaid Services, including Community First Choice, if living at home.

Technical Eligibility: Age 18 and older.

Financial Eligibility: Eligibility for Medicaid depends on an individual's income and assets. Individuals are encouraged to apply so that financial eligibility can be determined.

Medical Eligibility: Individuals must need the level of care required to qualify for nursing facility services.

For More Information Contact the Maryland Access Point at 1-844-627-5465.

I freely choose to participate in the Money Follows the Person program. I understand that this program allows me to receive a limited amount of flexible funds for expenses related to my transition from the facility where I currently live to a new home in the community. I understand these funds may be used for groceries, transportation expenses, and other costs directly related to my transition. I understand that my transition coordinator will help me access and document my use of these funds. I understand these funds are available only after I am determined eligible for the Money Follows the Person program and up to 60 days after I transition to the community. I understand that I will receive no additional benefits or services under the Money Follows the Person program beyond the flexible funds.

I understand that agreeing to participate in the Money Follows the Person program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my Money Follows the Person program eligibility. I understand that there are no additional risks anticipated based on my participation in the Money Follows the Person program beyond the risks related to receiving services in a community setting, for which I have already provided my consent.

In order to participate in the Money Follows the Person program, I have been informed that I must meet all of the eligibility requirements specific to the Money Follows the Person program, which include sixty (60) days living in a qualified institution, such as a nursing facility or State Residential Center, Medicaid eligibility prior to my date of transition to the community, and finally that I must choose to live in a qualified residence, defined as:

1. A home owned or leased by myself or a family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 3 other unrelated individuals reside.

As an MFP participant, I may be asked to complete three short surveys about my quality of life. I will still be eligible to receive flexible funds for transition even if I do not complete the surveys.

My signature below indicates that I agree to participate in the Money Follows the Person program if I am determined eligible and that any questions that I may have about the program have been answered.

Personal Information (Please print)

(Last)

(First)

(SSN#)

(MA#)

(Signature)

(Date)

EXHIBIT 22

Community-Based Services Guide

Introduction

This guide provides information on alternative placements to a skilled nursing facility for prospective and/or newly admitted residents. These alternatives include hospice care, home health care, and home care. Each option offers different levels of care and services to meet the needs of residents in various situations.

Home Health Care

Home health care involves a range of health care services that can be provided in the comfort of the patient's home. It is typically less expensive and more convenient than receiving care in a hospital or skilled nursing facility. Home health care is suitable for individuals who are recovering from an illness, injury, or surgery, and need medical support at home.

Services Provided:

- Skilled nursing care
- Physical, occupational, and speech therapy
- Medical social services
- Assistance with medications and medical equipment
- Monitoring of health status and vital signs

Home Care

Home care provides non-medical support and assistance with daily activities for individuals who need help to live independently at home. Home care services can be tailored to meet the specific needs of the individual and can range from a few hours a day to 24/7 care.

Services Provided:

- Assistance with personal care (bathing, dressing, grooming)
- Meal preparation and feeding
- Light housekeeping and laundry
- Companionship and socialization
- Transportation to appointments and errands

Hospice Care

Hospice care is a type of care designed to provide comfort and support to individuals who are in the final stages of a terminal illness. The focus is on quality of life rather than curative treatment. Hospice care can be provided in various settings, including the patient's home, hospice centers, hospitals, and long-term care facilities.

Services Provided:

- Pain and symptom management
- Emotional and spiritual support
- Assistance with daily activities
- Respite care for family caregivers
- Bereavement support for families

Conclusion

Choosing the right type of care for yourself or a loved one is an important decision. It is essential to consider the individual's medical needs, personal preferences, and the level of support required. Hospice care, home health care, and home care are valuable alternatives to skilled nursing facilities, each offering unique benefits to enhance the quality of life for residents. We encourage you to speak with our Social Worker to identify possible alternative options.

EXHIBIT 23

Care Plans, Comprehensive Person-Centered

Policy Statement

A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

Policy Interpretation and Implementation

1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.
2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.
3. The IDT includes:
 - a. the attending physician;
 - b. a registered nurse who has responsibility for the resident;
 - c. a nurse aide who has responsibility for the resident;
 - d. a member of the food and nutrition services staff;
 - e. the resident and the resident's legal representative (to the extent practicable); and
 - f. other appropriate staff or professionals as determined by the resident's needs or as requested by the resident.
4. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:
 - a. participate in the planning process;
 - b. identify individuals or roles to be included;
 - c. request meetings;
 - d. request revisions to the plan of care;
 - e. participate in establishing the expected goals and outcomes of care;
 - f. participate in determining the type, amount, frequency and duration of care;
 - g. receive the services and/or items included in the plan of care; and
 - h. see the care plan and sign it after significant changes are made.
5. The resident will be informed of his or her right to participate in his or her treatment.
6. An explanation will be included in a resident's medical record if the participation of the resident and his/her resident representative for developing the resident's care plan is determined to not be practicable.
7. The care planning process will:
 - a. facilitate resident and/or representative involvement;
 - b. include an assessment of the resident's strengths and needs; and
 - c. incorporate the resident's personal and cultural preferences in developing the goals of care.

continues on next page

8. The comprehensive, person-centered care plan will:
 - a. include measurable objectives and timeframes;
 - b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;
 - c. describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;
 - d. describe any specialized services to be provided as a result of PASARR recommendations;
 - e. include the resident's stated goals upon admission and desired outcomes;
 - f. include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire;
 - g. incorporate identified problem areas;
 - h. incorporate risk factors associated with identified problems;
 - i. build on the resident's strengths;
 - j. reflect the resident's expressed wishes regarding care and treatment goals;
 - k. reflect treatment goals, timetables and objectives in measurable outcomes;
 - l. identify the professional services that are responsible for each element of care;
 - m. aid in preventing or reducing decline in the resident's functional status and/or functional levels;
 - n. enhance the optimal functioning of the resident by focusing on a rehabilitative program; and
 - o. reflect currently recognized standards of practice for problem areas and conditions.
9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan.
10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.
 - a. No single discipline can manage an approach in isolation.
 - b. The resident's physician (or primary healthcare provider) is integral to this process.
11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.
 - a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers.
 - b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident.
12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).
13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.
14. The interdisciplinary team must review and update the care plan:
 - a. when there has been a significant change in the resident's condition;
 - b. when the desired outcome is not met;
 - c. when the resident has been readmitted to the facility from a hospital stay; and
 - d. at least quarterly, in conjunction with the required quarterly MDS assessment.

continues on next page

15. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies.

References	
OBRA Regulatory Reference Numbers	§483.21(a) Baseline Care Plans; §483.21(b) Comprehensive Care Plans; §483.21(b) Comprehensive Care Plans
Survey Tag Numbers	F655; F656; F657
Other References	
Related Documents	Care Area Assessments Care Planning – Interdisciplinary Team Resident Participation – Assessment/Care Plans
Version	1.3 (H5MAPL0110)

EXHIBIT 24

INFECTION
PREVENTION &
CONTROL

F-880

SS = D

Corrective Action:

- Corrective actions have been ensured by the Director of Nursing. Residents #5, #10, and #13 experienced no noted negative outcomes relates to the noted infection control concerns. The medications in the medication cart for Resident #5 have been sanitized to ensure no infection control concerns. LPN #10 has been educated regarding infection control standards and sanitation requirements. LPN #10 was educated regarding the requirement to sanitize their hands between residents when administering medications or providing care. LPN #10 was educated regarding the requirement to sanitize their hands after handling equipment and before providing water to residents. The syringes noted as accessible were properly discarded in the sharps container and are no longer be accessible. All nursing staff members will be educated on the proper utilization of the sharps container and ensuring that no used syringes are accessible, and the lever has been pulled to properly secure storage and discarding of the used syringes. All nursing staff members will be educated on proper infection control, sanitation, and hand hygiene requirements, including during medication administration.

Identification of Other Residents:

- All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility has system for daily nursing management rounds will be updated to include a focus on ensuring infection control compliance, including during medication administration.

System Changes:

- The Root Cause of the concern was a failure to adhere to the facility policy for “Infection Prevention and Control

Program” (rev. 10.2018). The facility policy for “Infection Prevention and Control Program” (rev. 10.2018) was reviewed and found to meet professional standards. All nursing staff members will be reeducated regarding the requirements of infection control, including proper infection control, sanitation, and hand hygiene requirements during medication administration and also the proper utilization of the sharps container and ensuring that no used syringes are accessible, and the lever has been pulled to properly secure storage and discarding of the used syringes. The facility system for managing the Infection Prevention and Control Program has been updated to include a system for daily IDT rounds (5 days a week x1 month, 3 days a week ongoing) which has been updated to include a focus on ensuring infection control compliance, including during medication administration. A monthly review of compliance with Infection Control standards in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The nursing management team (i.e. DON, MDS Coordinator, Wellness RN) will provide oversight to ensure ongoing compliance.

Success Evaluation:

- An Infection Control compliance audit to ensure proper Infection Control compliance, including during medication administration, will be completed by the Director of Nursing or designee (i.e. DON, MDS Coordinator, Wellness RN) on a random sample of 10% of residents; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. The results of the

	<p>audits will be provided to the QAPI Committee by the DON or Designee (i.e. DON, MDS Coordinator, Wellness RN) monthly for the next 3 months to determine the need for continued monitoring.</p>
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EXHIBIT 25

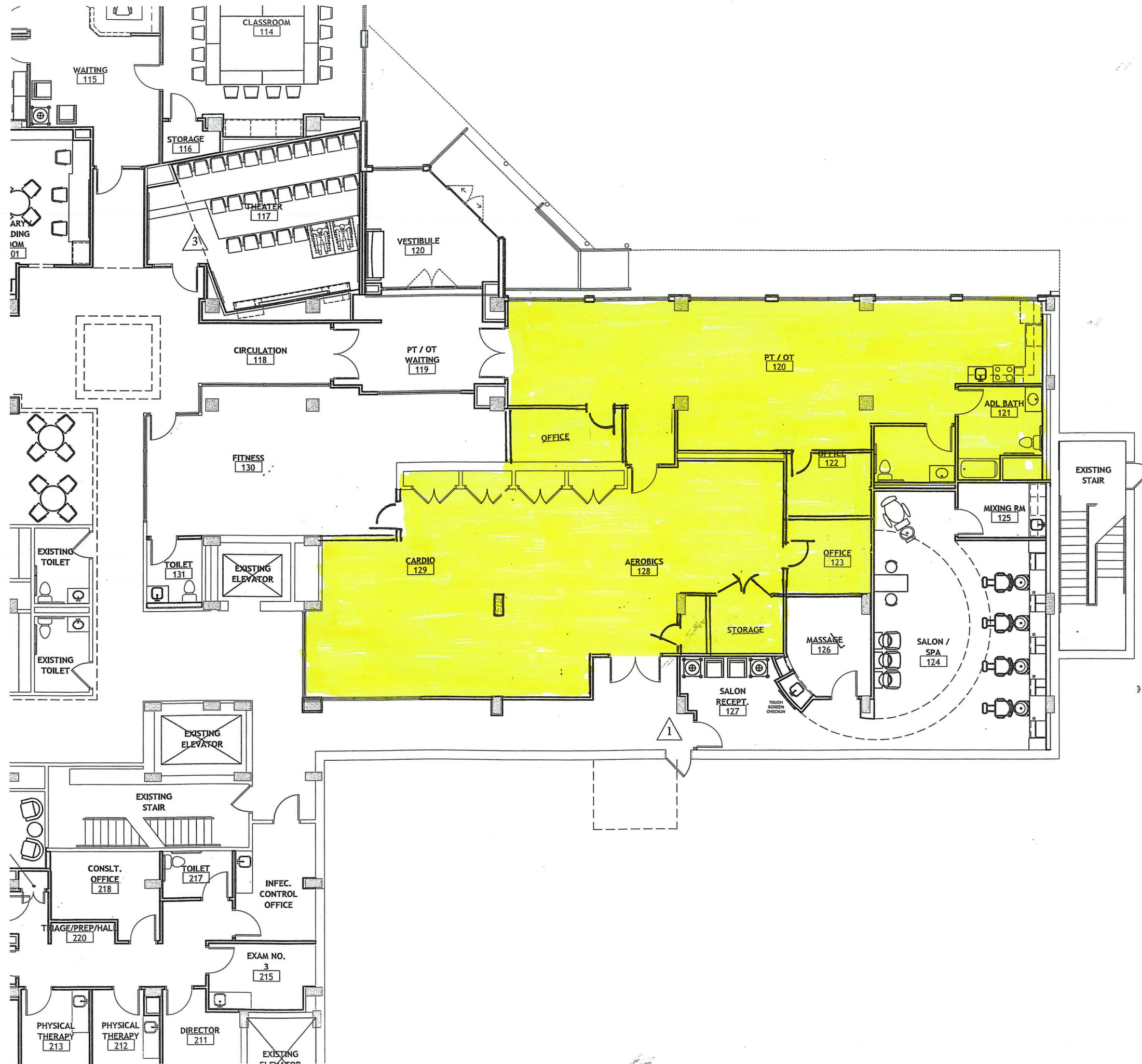


EXHIBIT 26

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
10:00 Sing Along w/ Susie Q 10:30 Daily Readings 11:00 Entertainment w/ Bob Clark 1:00 IN2L Travel Tour 1:30 Ball Toss 2:00 Get moving w/ Parachute 2:30 Finish the Phrase/Lyrics 3:30 Afternoon Social & Music 4:00 Meditation on IN2L <small>Shavuot Begins</small>	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 2:00 Monday Movie Moulin Rouge Popcorn & Drink provided 4:00 Get Moving w/ Exercise 4:30 TV Time 6:00 Game Shows	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Guess the Drawing Game 2:00 Entertainment with Vintage Entertainment 3:00 Crackers & Cheese Social 3:30 Afternoon Exercise 4:00 World Destination 6:00 Activities w/ Collin	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 1:30 Baking w/ Yamece - M 2:30 Trivia w/ Marilyn & Friends- M 3:00 Afternoon Social 3:30 Get Moving w/ Exercise 4:00 Card Game 4:30 Catholic Service 2nd Fl Aud	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Creative Art w/ Egypt 2:00 Sing Along w/ Kibler - M 3:00 Afternoon Social 3:30 Afternoon Exercise 4:00 National Geographic 6:00 Game Time w/ Collin	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Getting Pampered by Egypt 2:00 Sing Along w/ Peter Francis - M 3:00 Friday Social 3:30 Balloon Toss w/ Egypt 4:00 Group Trivia 4:30 TV Time	10:00 Sing Along w/ Mary Sue 10:30 Morning Exercise 11:00 Daily Chronicle Reading 11:30 Mind Aerobics (Trivia) 1:30 Games IN2L 2:30 It's Show Time 3:30 Afternoon Social 4:00 Basket Ball 4:30 Residents Choice	
10:00 Sing Along w/ Susie Q 10:30 Daily Readings 11:00 Stretch & Flex 11:30 Songs of Inspiration & Praise 1:00 IN2L Travel Tour 1:30 Ball Toss 2:00 Get moving w/ Parachute 2:30 Finish the Phrase/Lyrics 3:30 Afternoon Social & Music 4:00 Meditation on IN2L	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 2:00 Monday Movie Being Julia Popcorn & Drink provided 4:00 Get Moving w/ Exercise 4:30 TV Time 6:00 Game Shows	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Guess the Drawing Game 2:00 Entertainment with Charles Lee 3:00 Crackers & Cheese Social 3:30 Afternoon Exercise 4:00 World Destination 6:00 Activities w/ Collin	10:00 1-1 w/ Egypt 10:30 Tap w/ Marilyn 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 1:30 Baking w/ Yamece - M 2:30 Trivia w/ Marilyn & Friends- M 3:00 Afternoon Social 3:30 Get Moving w/ Exercise 4:00 Card Game 4:30 Catholic Service 2nd Fl Aud	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Arts & Crafts w/ Egypt 2:00 Lets go Bowling 3:00 Afternoon Social 3:30 Afternoon Exercise 4:00 National Geographic 6:00 Game Time w/ Collin	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt Reading Circle 2:00 Outside to the Terrace – 2 nd Fl 3:00 Friday Social 3:30 Ball Toss w/ Egypt 4:00 Group Trivia 4:30 TV Time	10:00 Sing Along w/ Mary Sue 10:30 Morning Exercise 11:00 Daily Chronicle Reading 11:30 Mind Aerobics (Trivia) 1:30 Games IN2L 2:30 It's Show Time 3:30 Afternoon Social 4:00 Basket Ball 4:30 Residents Choice <small>Flag Day (U.S.)</small>	
10:00 Sing Along w/ Susie Q 10:30 Daily Readings 11:00 Entertainment w/ Bob Clark 1:00 IN2L Travel Tour 1:30 Ball Toss 2:00 Get moving w/ Parachute 2:30 Finish the Phrase/Lyrics 3:30 Afternoon Social & Music 4:00 Meditation on IN2L <small>Father's Day</small>	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Centers w/ Marilyn High Society Popcorn & Drink provided 4:00 Get Moving w/ Exercise 4:30 TV Time 6:00 Game Shows	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Guess the Drawing Game 2:00 Entertainment with Steve Flynn 3:00 Crackers & Cheese Social 3:30 Afternoon Exercise 4:00 World Destination 6:00 Activities w/ Collin	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 1:30 Baking w/ Yamece - M 2:30 Trivia w/ Marilyn & Friends- M 3:00 Afternoon Social 3:30 Get Moving w/ Exercise 4:00 Card Game 4:30 Catholic Service 2nd Fl Aud	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Resident Council Let Your Voice Be Heard 2:00 Sing Along w/ Kibler - M 3:00 Afternoon Social 3:30 Afternoon Exercise 4:00 National Geographic 6:00 Game Time w/ Collin <small>Juneteenth</small>	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt Reading Circle 2:00 Outside to the Terrace – 2nd Fl 3:00 Friday Social 3:30 Ball Toss w/ Egypt 4:00 Group Trivia 4:30 TV Time <small>Summer Begins</small>	10:00 Sing Along w/ Mary Sue 10:30 Morning Exercise 11:00 Daily Chronicle Reading 11:30 Mind Aerobics (Trivia) 1:30 Games IN2L 2:30 It's Show Time 3:30 Afternoon Social 4:00 Basket Ball 4:30 Residents Choice	
10:00 Sing Along w/ Susie Q 10:30 Daily Readings 11:00 Stretch & Flex 11:30 Songs of Inspiration & Praise 1:00 IN2L Travel Tour 1:30 Ball Toss 2:00 Get moving w/ Parachute 2:30 Finish the Phrase/Lyrics 3:30 Afternoon Social & Music 4:00 Meditation on IN2L	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 2:00 Monday Movie Brides Maids Popcorn & Drink provided 4:00 Get Moving w/ Exercise 4:30 TV Time 6:00 Game Shows	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Guess the Drawing Game 2:00 Outside to the Terrace – 2 nd Fl 3:00 Crackers & Cheese Social 3:30 Afternoon Exercise 4:00 World Destination 6:00 Activities w/ Collin	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 1:30 Baking w/ Yamece - M 2:30 Trivia w/ Marilyn & Friends- M 3:00 Afternoon Social 3:30 Get Moving w/ Exercise 4:00 Card Game 4:30 Catholic Service 2nd Fl Aud	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Arts & Crafts w/ Egypt 1:45 Scenic Ride on the Bus 3:00 Afternoon Social 3:30 Afternoon Exercise 4:00 National Geographic 6:00 Game Time w/ Collin	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 2:00 Get Moving with Positive Music by DJ Randy - M 3:00 Friday Social 3:30 Balloon Toss w/ Egypt 4:00 Group Trivia 4:30 TV Time	10:00 Sing Along w/ Mary Sue 10:30 Morning Exercise 11:00 Daily Chronicle Reading 11:30 Mind Aerobics (Trivia) 1:30 Games IN2L 2:30 It's Show Time 3:30 Afternoon Social 4:00 Basket Ball 4:30 Residents Choice	
10:00 Sing Along w/ Susie Q 10:30 Daily Readings 11:00 Stretch & Flex 11:30 Songs of Inspiration & Praise 1:00 IN2L Travel Tour 1:30 Ball Toss 2:00 Get moving w/ Parachute 2:30 Finish the Phrase/Lyrics 3:30 Afternoon Social & Music 4:00 Meditation on IN2L	10:00 1-1 w/ Egypt 11:00 Daily Readings 11:30 Magic Table 1:00 Egypt's Reading Circle 2:00 Monday Movie Breakfast at Tiffany's Popcorn & Drink provided 4:00 Get Moving w/ Exercise 4:30 TV Time 6:00 Game Shows	 <h1 style="font-size: 4em; color: #0056b3; text-align: center;">June 2025</h1> <h2 style="font-size: 2em; color: #0056b3; text-align: center;">CEDAR PLACE</h2>					

Residences at Vantage Point – Please note that activities can be change anytime due to resident's preferences

All weekend activities are on Monterey Place M=Monterey Place – 5th unless noted

EXHIBIT 27



Winter Growth

Where friendships grow and care is extraordinary

June 30, 2025

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Letter of Partnership – Residences at Vantage Point CON Application for
Skilled Nursing Facility

To Whom It May Concern,

On behalf of Winter Growth, I am pleased to express our support for the Residences at Vantage Point (RVP) as they pursue a Certificate of Need (CON) for the development of a Skilled Nursing Facility on their Columbia campus.

Winter Growth and RVP share a long-standing history of partnership rooted in our mutual mission to support older adults in aging with dignity, purpose, and community. As neighboring organizations located in the heart of Columbia, Maryland, we have worked closely together over the years to support seniors in Howard County.

We believe that the addition of a skilled nursing facility at RVP will significantly enhance the continuum of care available to older adults in our shared community. The proximity of our Adult Day Program to RVP's proposed facility presents unique opportunities for collaboration—particularly in supporting older adults as they transition between care levels and seek alternatives to premature long-term institutionalization.

We look forward to continuing and strengthening our partnership with RVP as they expand their service offerings. This letter is intended to affirm our commitment to ongoing collaboration and to identify Winter Growth as a potential partner should the CON be approved. While non-binding, we see this as a meaningful step forward in supporting a more integrated and responsive senior care network in Howard County.

Sincerely,

Cheri C. Sanzi
CEO

Sarah Ebeling
Center Director, Howard County



EXHIBIT 28

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.

Before the Project						After Project Completion				
Service Location (Floor/Wing)	Current Licensed Beds	Based on Physical Capacity				Based on Physical Capacity				
		Room Count			Physical Bed Capacity	Service Location (Floor/Wing)	Room Count			Physical Bed Capacity
		Private	Semi-Private	Total Rooms			Private	Semi-Private	Total Rooms	
COMPREHENSIVE CARE						COMPREHENSIVE CARE				
Health Center	44	16	14	30	44	Health Center	16	14	30	44
				0	0				0	0
				0	0				0	0
				0	0				0	0
				0	0				0	0
SUBTOTAL Comprehensive Care	44	16	14	30	44	SUBTOTAL	16	14	30	44
ASSISTED LIVING						ASSISTED LIVING				
Assisted Living/Memory Care	50	50		50	50	Assisted Living/Memory Care	50		50	50
TOTAL ASSISTED LIVING	50	50		50	50	TOTAL ASSISTED LIVING	50		50	50
Other (Specify/add rows as needed)	200	200		200	200	Other (Specify/add rows as needed)	200		200	200
TOTAL OTHER	200	200		200	200	TOTAL OTHER	200		200	200
FACILITY TOTAL	294	266	14	280	294	FACILITY TOTAL	266	14	280	294

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). 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.d 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 (Specify/add rows if needed)			\$0
SUBTOTAL Other Capital Costs	\$0	\$0	\$0
TOTAL CURRENT CAPITAL COSTS	\$0	\$0	\$0
d. Land Purchased/Donated			
e. Inflation Allowance			
TOTAL CAPITAL COSTS	\$0	\$0	\$0
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			\$0
b. Bond Discount			\$0
c. CON Application Assistance			
c1. Legal Fees			\$0
c2. Other (Specify/add rows if needed)			
d. Non-CON Consulting Fees			\$0
d1. Legal Fees			
d2. Other (Specify/add rows if needed)			\$0
e. Debt Service Reserve Fund			\$0
f. Other (Specify/add rows if needed)			\$0
SUBTOTAL	\$0	\$0	\$0
3. Working Capital Startup Costs			\$0
TOTAL USES OF FUNDS	\$0	\$0	\$0
B. Sources of Funds			
1. Cash			\$0
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			\$0

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.

Indicate CY or FY	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.						
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031	FY 2032
1. ADMISSIONS										
a. Comprehensive Care (public)	n/a	n/a	n/a	45	65	65	65	65	65	65
b. Comprehensive Care (CCRC Restricted)	65	64	65	65	65	65	65	65	65	65
Total Comprehensive Care	65	64	65	110	130	130	130	130	130	130
c. Assisted Living	26	21	12	20	20	20	20	20	20	20
d. Other (Independent Living)	18	31	26	24	24	24	24	24	24	24
TOTAL ADMISSIONS	109	116	103	154	174	174	174	174	174	174
2. PATIENT DAYS										
a. Comprehensive Care (public)	n/a	n/a	n/a	2,738	3,650	3,650	3,650	3,650	3,650	3,650
b. Comprehensive Care (CCRC Restricted)	6,570	7,574	7,300	6,570	6,570	6,570	6,570	6,570	6,570	6,570
Total Comprehensive Care	6,570	7,574	7,300	9,308	10,220	10,220	10,220	10,220	10,220	10,220
c. Assisted Living	12,684	14,326	14,509	14,600	14,600	14,600	14,600	14,600	14,600	14,600
d. Other (Independent Living)	65,791	66,613	67,069	66,795	66,795	66,978	66,795	66,795	66,795	66,978
TOTAL PATIENT DAYS	85,045	88,513	88,878	90,703	91,615	91,798	91,615	91,615	91,615	91,798
3. NUMBER OF BEDS										
a. Comprehensive Care (public)	0	0	0	13	13	13	13	13	13	13
b. Comprehensive Care (CCRC Restricted)	44	44	44	31	31	31	31	31	31	31
Total Comprehensive Care Beds	44	44	44	44	44	44	44	44	44	44
c. Assisted Living	50	50	50	50	50	50	50	50	50	50
d. Other (Independent Living)	200	200	200	200	200	200	200	200	200	200
TOTAL BEDS	294	294	294	294	294	294	294	294	294	294

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.

	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.						
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031	FY 2032
<i>Indicate CY or FY</i>										
4. OCCUPANCY PERCENTAGE <i>*IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.</i>										
a. Comprehensive Care (public)	N/A	N/A	N/A	57.7%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%
b. Comprehensive Care (CCRC Restricted)	40.9%	47.2%	45.5%	58.1%	58.1%	58.1%	58.1%	58.1%	58.1%	58.1%
Total Comprehensive Care Beds	40.9%	47.2%	45.5%	58.0%	63.6%	63.6%	63.6%	63.6%	63.6%	63.6%
c. Assisted Living	69.5%	78.5%	79.5%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
d. Other (Independent Living)	90.1%	91.3%	91.9%	91.5%	91.5%	91.8%	91.5%	91.5%	91.5%	91.8%
TOTAL OCCUPANCY %	79.3%	82.3%	82.8%	84.5%	85.4%	85.3%	85.4%	85.4%	85.4%	85.3%
5. OUTPATIENT (specify units used for charging and recording revenues)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
a. Adult Day Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031	FY 2032
1. ADMISSIONS							
a. Comprehensive Care (public)	45	65	65	65	65	65	65
b. Comprehensive Care (CCRC Restricted)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Comprehensive Care	45	65	65	65	65	65	65
c. Assisted Living	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL ADMISSIONS	45	65	65	65	65	65	65
2. PATIENT DAYS							
a. Comprehensive Care (public)	2,738	3,650	3,660	3,650	3,650	3,650	3,660
b. Comprehensive Care (CCRC Restricted)	0	0	0	0	0	0	0
Total Comprehensive Care	2,738	3,650	3,660	3,650	3,650	3,650	3,660
c. Assisted Living	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL PATIENT DAYS	2,738	3,650	3,660	3,650	3,650	3,650	3,660
3. NUMBER OF BEDS	13	13	13	13	13	13	13
a. Comprehensive Care (public)	13	13	13	13	13	13	13
b. Comprehensive Care (CCRC Restricted)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Comprehensive Care Beds	13	13	13	13	13	13	13
c. Assisted Living	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL BEDS	13	13	13	13	13	13	13
4. OCCUPANCY PERCENTAGE *IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.							
a. Comprehensive Care (public)	57.7%	76.9%	77.1%	76.9%	76.9%	76.9%	77.1%
b. Comprehensive Care (CCRC Restricted)	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Total Comprehensive Care Beds	57.7%	76.9%	77.1%	76.9%	76.9%	76.9%	77.1%
c. Assisted Living	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
d. Other (Specify/add rows of needed)	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
TOTAL OCCUPANCY %	57.7%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%
5. OUTPATIENT (specify units used for charging and recording revenues)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
a. Adult Day Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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.

	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.						
	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031	FY 2032
1. REVENUE										
a. Inpatient Services	\$ 16,821,306	\$ 19,371,011	\$ 19,724,252	\$ 20,872,698	\$ 21,273,531	\$ 21,277,776	\$ 21,273,531	\$ 21,273,531	\$ 21,273,531	\$ 21,277,776
b. Outpatient Services	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Patient Service Revenues	\$ 16,821,306	\$ 19,371,011	\$ 19,724,252	\$ 20,872,698	\$ 21,273,531	\$ 21,277,776	\$ 21,273,531	\$ 21,273,531	\$ 21,273,531	\$ 21,277,776
c. Allowance For Bad Debt	\$ -	\$ 102,302	\$ 65,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000
d. Contractual Allowance	\$ 537,536	\$ 616,302	\$ 643,679	\$ 835,304	\$ 935,679	\$ 936,479	\$ 935,679	\$ 935,679	\$ 936,479	\$ 936,479
e. Charity Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Net Patient Services Revenue	\$ 16,283,770	\$ 18,652,407	\$ 19,015,573	\$ 19,987,394	\$ 20,287,852	\$ 20,291,297	\$ 20,287,852	\$ 20,287,852	\$ 20,287,052	\$ 20,291,297
f. Other Operating Revenues (Earned Entrance Fees)	\$ 1,615,043	\$ 1,938,342	\$ 2,779,278	\$ 2,918,242	\$ 2,918,242	\$ 2,918,242	\$ 2,918,242	\$ 2,918,242	\$ 2,918,242	\$ 2,918,242
f. Other Operating Revenues (Other)	\$ 70,551	\$ 210,733	\$ 175,000	\$ 175,000	\$ 175,000	\$ 175,000	\$ 175,000	\$ 175,000	\$ 175,000	\$ 175,000
NET OPERATING REVENUE	\$ 17,969,364	\$ 20,801,482	\$ 21,969,851	\$ 23,080,636	\$ 23,381,094	\$ 23,384,539	\$ 23,381,094	\$ 23,381,094	\$ 23,380,294	\$ 23,384,539
2. EXPENSES										
a. Salaries & Wages (including benefits)	\$ 8,417,501	\$ 9,388,862	\$ 9,731,520	\$ 10,336,615	\$ 10,499,820	\$ 10,501,925	\$ 10,499,820	\$ 10,499,820	\$ 10,499,820	\$ 10,501,925
b. Contractual Services	\$ 1,254,592	\$ 1,501,366	\$ 1,573,265	\$ 1,764,890	\$ 1,865,265	\$ 1,866,065	\$ 1,865,265	\$ 1,865,265	\$ 1,866,065	\$ 1,865,265
c. Interest on Current Debt	\$ 2,262,875	\$ 2,188,224	\$ 2,114,552	\$ 2,080,250	\$ 2,038,645	\$ 1,997,872	\$ 1,957,915	\$ 1,918,756	\$ 1,880,381	\$ 1,842,774
d. Interest on Project Debt	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
e. Current Depreciation	\$ 3,425,468	\$ 3,641,756	\$ 3,547,862	\$ 3,547,862	\$ 3,547,862	\$ 3,547,862	\$ 3,547,862	\$ 3,547,862	\$ 3,547,862	\$ 3,547,862
f. Project Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
g. Current Amortization	\$ 10,602	\$ 10,497	\$ 12,089	\$ 13,500	\$ 13,500	\$ 13,500	\$ 13,500	\$ 13,500	\$ 13,500	\$ 13,500
h. Project Amortization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
i. Supplies	\$ 435,778	\$ 499,352	\$ 523,670	\$ 537,360	\$ 545,570	\$ 545,570	\$ 545,570	\$ 545,570	\$ 545,570	\$ 545,570
j. Other Expenses (Utilities)	\$ 633,897	\$ 668,975	\$ 802,330	\$ 802,330	\$ 802,330	\$ 802,330	\$ 802,330	\$ 802,330	\$ 802,330	\$ 802,330
j. Other Expenses (Food)	\$ 986,210	\$ 1,058,281	\$ 1,108,850	\$ 1,138,641	\$ 1,149,000	\$ 1,149,000	\$ 1,149,000	\$ 1,149,000	\$ 1,149,000	\$ 1,149,000
j. Other Expenses (Marketing)	\$ 430,698	\$ 461,051	\$ 409,947	\$ 475,000	\$ 475,000	\$ 475,000	\$ 475,000	\$ 475,000	\$ 475,000	\$ 475,000
j. Other Expenses (Administrative)	\$ 1,847,321	\$ 2,099,018	\$ 1,965,575	\$ 2,072,895	\$ 2,005,352	\$ 2,005,352	\$ 2,005,352	\$ 2,005,352	\$ 2,005,352	\$ 2,005,352
TOTAL OPERATING EXPENSES	\$ 19,704,942	\$ 21,517,382	\$ 21,789,660	\$ 22,769,344	\$ 22,942,344	\$ 22,904,477	\$ 22,861,614	\$ 22,822,456	\$ 22,784,881	\$ 22,748,578

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.

	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.						
3. INCOME										
a. Income From Operation	\$ (1,735,578)	\$ (715,900)	\$ 180,191	\$ 311,292	\$ 438,749	\$ 480,062	\$ 519,480	\$ 558,638	\$ 595,413	\$ 635,961
b. Non-Operating Income	\$ 953,494	\$ 1,115,410	\$ 747,651	\$ 275,000	\$ 275,000	\$ 275,000	\$ 275,000	\$ 275,000	\$ 275,000	\$ 275,000
SUBTOTAL	\$ (782,084)	\$ 399,510	\$ 927,842	\$ 586,292	\$ 713,749	\$ 755,062	\$ 794,480	\$ 833,638	\$ 870,413	\$ 910,961
c. Income Taxes	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NET INCOME (LOSS)	\$ (782,084)	\$ 399,510	\$ 927,842	\$ 586,292	\$ 713,749	\$ 755,062	\$ 794,480	\$ 833,638	\$ 870,413	\$ 910,961
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	3.5%	3.5%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
2) Medicaid	0.0%	0.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
3) Blue Cross										
4) Commercial Insurance	0.3%	0.7%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
5) Self-pay										
6) CCRC Residents	96.2%	95.8%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
b. Percent of Inpatient Days										
1) Medicare	1.2%	1.5%	1.6%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%
2) Medicaid	N/A	N/A	N/A	1.51%	1.99%	1.99%	1.99%	1.99%	1.99%	1.99%
3) Blue Cross										
4) Commercial Insurance	0.1%	0.2%	0.4%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
5) Self-pay										
6) CCRC Residents	98.7%	98.3%	98.0%	95.3%	94.8%	94.8%	94.8%	94.8%	94.8%	94.8%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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								
Staff Category	Weekday Hours Per Day				Weekend Hours Per Day			
	Day	Evening	Night	Total	Day	Evening	Night	Total
Registered Nurses	8	8	8	24	8	8	8	24
L. P. N. s	8	8	0	16	8	8		16
Aides				0				0
C. N. A.s	22.5	15	15	52.5	22.5	15	15	52.5
Medicine Aides				0				
Total	38.5	31	23	92.5	38.5	31	23	92.5
Licensed Beds at Project Completion				44	Licensed Beds at Project Completion			44
Hours of Bedside Care per Licensed Bed per Day				0.91	Hours of Bedside Care per Licensed Bed Per Day			0.91
Staff Category	Weekday Hours Per Day				Weekend Hours Per Day			
	Day	Evening	Night	Total	Day	Evening	Night	Total
Ward Clerks (bedside care time calculated at 50%)	16			16	0			0
Total Including 50% of Ward Clerks Time				48	0			40
Total Hours of Bedside Care per Licensed Bed Per Day				1.09	Total Hours of Bedside Care per Licensed Bed Per Day			0.91

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.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031	FY 2032
1. REVENUE							
a. Inpatient Services	\$ 1,148,446	\$ 1,549,279	\$ 1,553,524	\$ 1,549,279	\$ 1,549,279	\$ 1,549,279	\$ 1,553,524
b. Outpatient Services	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Patient Service Revenues	\$ 1,148,446	\$ 1,549,279	\$ 1,553,524	\$ 1,549,279	\$ 1,549,279	\$ 1,549,279	\$ 1,553,524
c. Allowance For Bad Debt	\$ 11,484	\$ 15,493	\$ 15,958	\$ 15,493	\$ 15,493	\$ 15,493	\$ 15,958
d. Contractual Allowance	\$ 191,625	\$ 292,000	\$ 292,800	\$ 292,000	\$ 292,000	\$ 292,800	\$ 274,498
e. Charity Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Net Patient Services Revenue	\$ 945,337	\$ 1,241,786	\$ 1,244,766	\$ 1,241,786	\$ 1,241,786	\$ 1,240,986	\$ 1,263,068
f. Other Operating Revenues (Specify)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NET OPERATING REVENUE	\$ 945,337	\$ 1,241,786	\$ 1,244,766	\$ 1,241,786	\$ 1,241,786	\$ 1,240,986	\$ 1,263,068
2. EXPENSES							
a. Salaries & Wages (including benefits)	\$ 605,095	\$ 768,300	\$ 770,405	\$ 768,300	\$ 768,300	\$ 768,300	\$ 770,405
b. Contractual Services	\$ 134,138	\$ 204,400	\$ 204,960	\$ 204,400	\$ 204,400	\$ 204,960	\$ 192,149
c. Interest on Current Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d. Interest on Project Debt	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e. Current Depreciation	N/A	N/A	N/A	N/A	N/A	N/A	N/A
f. Project Depreciation	N/A	N/A	N/A	N/A	N/A	N/A	N/A
g. Current Amortization	N/A	N/A	N/A	N/A	N/A	N/A	N/A
h. Project Amortization	N/A	N/A	N/A	N/A	N/A	N/A	N/A
i. Supplies	\$ 13,690	\$ 21,900	\$ 21,900	\$ 21,900	\$ 21,900	\$ 21,900	\$ 21,900
j. Other Expenses (Utilities)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
j. Other Expenses (Food)	\$ 29,791	\$ 40,150	\$ 40,150	\$ 40,150	\$ 40,150	\$ 40,150	\$ 40,150
j. Other Expenses (Marketing)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
j. Other Expenses (Administrative)	\$ 27,128	\$ 39,777	\$ 39,777	\$ 39,777	\$ 39,777	\$ 39,777	\$ 39,777
TOTAL OPERATING EXPENSES	\$ 809,842	\$ 1,074,527	\$ 1,077,192	\$ 1,074,527	\$ 1,074,527	\$ 1,075,087	\$ 1,064,381
3. INCOME							
a. Income From Operation	\$ 135,495.30	\$ 167,259.21	\$ 167,574.00	\$ 167,259.21	\$ 167,259.21	\$ 165,899.21	\$ 198,687.40
b. Non-Operating Income	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
SUBTOTAL	\$ 135,495.30	\$ 167,259.21	\$ 167,574.00	\$ 167,259.21	\$ 167,259.21	\$ 165,899.21	\$ 198,687.40
c. Income Taxes	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NET INCOME (LOSS)	\$ 135,495.30	\$ 167,259.21	\$ 167,574.00	\$ 167,259.21	\$ 167,259.21	\$ 165,899.21	\$ 198,687.40
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	52.0%	52.0%	52.0%	52.0%	52.0%	52.0%	52.0%
2) Medicaid	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	18.0%	18.0%	18.0%	18.0%	18.0%	18.0%	18.0%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
b. Percent of Inpatient Days							
1) Medicare	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%
2) Medicaid	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

TABLE H. WORKFORCE INFORMATION

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

Job Category	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	
	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost (should be consistent with projections in Table G, if submitted)	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost (should be consistent with projections in Table G)
1. Regular Employees											
<i>Administration (List general categories, add rows if needed)</i>											
Administration	16.5	\$83,470	\$1,377,262	N/A	0.0	\$0	N/A	0.0	\$0	16.5	\$1,377,262
			\$0	N/A	0.0	\$0	N/A	0.0	\$0	0.0	\$0
			\$0	N/A	0.0	\$0	N/A	0.0	\$0	0.0	\$0
			\$0	N/A	0.0	\$0	N/A	0.0	\$0	0.0	\$0
Total Administration	16.5	83,470.4	1,377,261.6			\$0			\$0	16.5	\$1,377,262
<i>Direct Care Staff (List general categories, add rows if needed)</i>											
C.N.A	31.1	\$43,680	\$1,358,448	11.0	\$46,500	\$511,500	N/A	0.0	\$0	42.1	\$1,869,948
LPN	11.7	\$74,880	\$876,096	1.0	\$79,500	\$79,500	N/A	0.0	\$0	12.7	\$955,596
RN	4.4	\$91,520	\$402,688			\$0	N/A	0.0	\$0	4.4	\$402,688
			\$0			\$0	N/A	0.0	\$0	0.0	\$0
Total Direct Care	47.2	55,873.6	2,637,232.0	12.0	49,250.0	591,000.0			\$0	59.2	\$3,228,232
<i>Support Staff (List general categories, add rows if needed)</i>											
Food & Beverage Staffing	42.8	\$41,808	\$1,789,382	N/A	\$0	\$0	N/A	0.0	\$0	42.8	\$1,789,382
HouseKeeping	21.6	\$38,403	\$829,505	N/A	\$0	\$0	N/A	0.0	\$0	21.6	\$829,505
Maintenance	6.2	\$67,552	\$418,822	N/A	\$0	\$0	N/A	0.0	\$0	6.2	\$418,822
Security	5.4	\$39,936	\$215,654	N/A	\$0	\$0	N/A	0.0	\$0	5.4	\$215,654
Activities	3.6	\$43,680	\$157,248	N/A	\$0	\$0	N/A	0.0	\$0	3.6	\$157,248
Other	10.3	\$60,015	\$618,155	N/A	\$0	\$0	N/A	0.0	\$0	10.3	\$618,155
			\$0	N/A	\$0	\$0	N/A	0.0	\$0	0.0	\$0
Total Support	89.9	44,813.9	4,028,766.5	0.0	#DIV/0!	0.0			\$0	89.9	\$4,028,767
REGULAR EMPLOYEES TOTAL	153.6	52,365.0	8,043,260.1	12.0	49,250.0	591,000.0			\$0	165.6	\$8,634,260

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.

Job Category	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 DOLLARS)	
	Current Year FTEs	Average Salary per FTE	Current Year Total Cost	FTEs	Average Salary per FTE	Total Cost (should be consistent with projections in Table G, if submitted)	FTEs	Average Salary per FTE	Total Cost	FTEs	Total Cost (should be consistent with projections in Table G)
2. Contractual Employees											
Administration (List general categories, add rows if needed)											
Total Administration			\$0			\$0			\$0	0.0	\$0
Direct Care Staff (List general categories, add rows if needed)											
Total Direct Care Staff			\$0			\$0			\$0	0.0	\$0
Support Staff (List general categories, add rows if needed)											
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):											
TOTAL COST	153.6		\$8,043,260	12.0		\$591,000	0.0		\$0		\$8,634,260

EXHIBIT 29

AFFIRMATION

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

By:  _____

Printed Name: Pierce Carey

Title: Executive Director

Date: 7/21/25

AFFIRMATION

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

By: Joseph Mooney

Printed Name: Joe Mooney

Title: Finance Manager

Date: 7-21-25

AFFIRMATION

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

By: Kevin McDonald

Printed Name: Kevin McDonald

Title: Consultant

Date: July 21 2025