

EXHIBIT A

EXHIBIT A

Ownership:

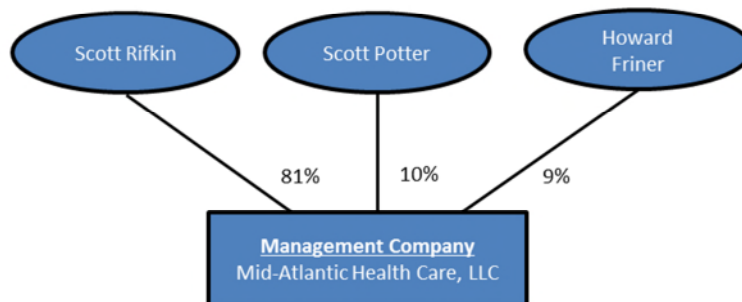
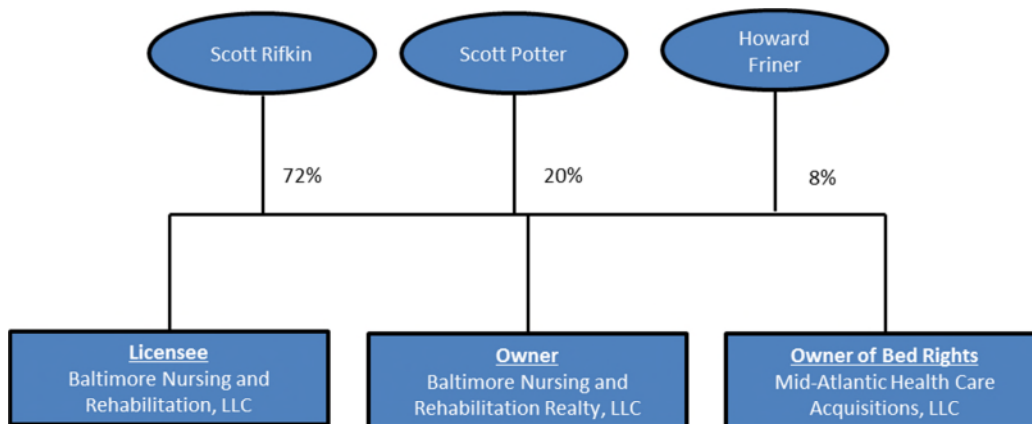


EXHIBIT B

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

James N. Elliott, M.D.

John M. Colmers

Adam Kane

Jack C. Keane



Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Clinical & Financial
Information

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hsrc.maryland.gov

Memorandum

Date: September 25, 2018

To: Paul Parker, Director, Health Care Facilities Planning and Development, Maryland Health Care Commission

From: Katie Wunderlich, Executive Director

Subject: Risk Construct for the Management of Medicare FFS Total Cost of Care in Partnership with Mid-Atlantic Health Care (Docket No. 15-24-2366)

Overview:

On August 3, 2018, the University of Maryland Medical System (UMMS) and Mid-Atlantic Health Care (MAHC) forwarded a proposal to take on responsibility for Medicare fee-for-service (FFS) Total Cost of Care for patients discharged from the University of Maryland Medical Center (UMMC) and UMMC Midtown Campus (UMMC Midtown) to a new skilled nursing facility (Restore Health) operated by MAHC for a three-year pilot period.

MAHC has submitted a Certificate of Need application to the Maryland Health Care Commission for the construction of Restore Health, an 80-bed nursing home in West Baltimore. Restore Health will be located within close proximity to UMMC and UMMC Midtown, and will provide the opportunity for close partnership between the entities for the care and rehabilitation of post-acute patients, especially those that are medically complex and require additional coordinated care upon discharge.

HSCRC Evaluation

The HSCRC has evaluated the proposed risk arrangement from UMMS in partnership with MAHC under the lens of the Total Cost of Care Model, which was recently approved by the Centers for Medicare & Medicaid Services. As of January 2019, the State will be required to progressively moderate the growth in total hospital and non-hospital cost of care for Maryland's Medicare patients relative to the national growth in these costs to produce annual savings to Medicare of \$300 million by 2023. In order to achieve this level of annual savings, hospitals will need to actively partner with post-acute providers, community-based providers, and others to improve care coordination, optimize care delivery, and improve health.

One way that hospitals and post-acute providers can work together is by participating in Maryland's newly created Episode Care Improvement Program (ECIP), designed to allow a hospital to link payments

across providers during an episode of care. Maryland modeled ECIP on CMS's Bundled Payments for Care Improvement Program Advanced. Episode payment models bundle payments to health care providers for certain items and services furnished during an episode of care. ECIP's bundled payment approach centers care around patients and aligns incentives across hospitals, physicians, and post-acute care facilities to improve quality and lower costs through better care management during episodes. This approach eliminates unnecessary care, optimizes post-acute care delivery, and reduces post-discharge emergency department visits and hospital readmissions. ECIP provides hospitals with the opportunity to provide incentive payments to care partners that help achieve these goals.

UMMS, in its Risk Construct proposal, stated its intent to participate in ECIP as a convener hospital, with Restore Health acting as the participating care partner. Participation in ECIP will provide a mechanism to limit the cost per episodes for patients discharged from UMMC or UMMC Midtown to Restore Health. Additionally, UMMS and MAHC commit to monitoring Medicare total cost of care, Medicaid nursing facility utilization and cost on an aggregate basis in the zip codes constituting the primary service area in West Baltimore.

UMMS and MAHC have agreed to work with HSCRC to address excessive cost and utilization growth, should it occur once the new facility is opened. UMMS would be accountable for excess cost growth through the Medicare Performance Adjustment and the ECIP bundled payments, and MAHC would be accountable through an agreement with UMMS. While the ECIP program may change or UMMS and MAHC may enter into alternative arrangements, the Maryland Total Cost of Care Model has a ten year duration, and UMMS will be subject to the Medicare Performance Adjustment on an ongoing basis. The Maryland Health Care Commission should note that UMMS will have ongoing responsibility for total cost of care performance for its service area regardless of whether or not this arrangement extends past the three-year pilot period.

Summary of Staff Findings

In summary, the proposal submitted by UMMS and MAHC provides substantial protection for three years against the potential for increased costs associated with the creation of a new 80-bed skilled nursing facility. The Medicare Performance Adjustment provides some level of protection against cost increases beyond the three-year period. Furthermore, UMMS and MAHC have agreed to work together to produce cost savings and improve quality for their patients. The upcoming Total Cost of Care Model is predicated on partnerships between hospital and non-hospital providers that can drive better quality and outcomes, while also lowering costs.

Please contact us if you have further questions.

CC: Ben Steffen

EXHIBIT C

EXHIBIT D

**Samples of Planned Interior Look from
Restore Health - Waldorf**



Entrance Lobby



Dining Room



Typical Hallway



Nurse's Station



Rehab Gym



Salon



Resident Room



Resident Bathroom

EXHIBIT E

250 W. Pratt Street
24th Floor
Baltimore, Maryland 21201-6829

October 10, 2018

George Watson
VP Corporate Development
Mid-Atlantic Health Care, LLC
1922 Greenspring Drive, Suite 6
Timonium, Maryland 21093

Re: Proposed development of comprehensive care facility of University of Maryland Medical Center Midtown Campus

Dear George:

The University of Maryland Medical Center Midtown Campus has previously sent support letters in connection with your proposed facility (Baltimore Nursing and Rehabilitation, LLC) seeking Certificate of Need (Docket No. 15-24-2366) from the Maryland Health Care Commission. The University of Maryland Medical Center has also entered into a proposed agreement with you to enter into a bundled arrangement when the facility opens dedicated to reducing the cost of acute and post-acute bundled care. You have informed us that you have lost the initial location of the planned facility due to delays in the approval process and are now seeking a new site.

This letter will confirm that we have had discussions with Mid-Atlantic concerning locating the facility on the campus of UMMC Midtown. We are excited at the prospect of having this modern facility focused heavily on reducing the cost of bundled acute and post-acute care for the patients we serve, which we believe will greatly assist the proposed coordinated treatment model that holds so much promise.

There are two potential building sites on our campus and for the purpose of confirming our support, we have identified the site of our existing Armory Building located at 300 Armory Way and Linden Avenue to locate the proposed facility. While more detailed planning remains to be done, we are confident that we will be able to proceed quickly once the project is approved. We understand that you will share this letter with the Maryland Health Care Commission, and consent to you doing so. We look forward to working with you on this worthwhile and innovative project.

Sincerely,



Keith D. Persinger
Chief Performance Improvement Officer

cc: Alison G. Brown, MPH, President, UMMC Midtown Campus
Scott Rifkin, M.D.
Suellen Wideman, Esquire, Assistant Attorney General
Kevin McDonald, Chief, Certificate of Need Division
Ruby Potter, Health Facilities Coordinator

UNIVERSITY OF MARYLAND MEDICAL SYSTEM

University of Maryland Medical Center • University of Maryland Medical Center Midtown Campus •
University of Maryland Rehabilitation and Orthopaedic Institute • University of Maryland Baltimore Washington Medical Center •
University of Maryland Shore Regional Health – University of Maryland Shore Medical Center at Easton -
University of Maryland Shore Medical Center at Chestertown - University of Maryland Shore Medical Center at Dorchester •
University of Maryland Charles Regional Medical Center • University of Maryland St. Joseph Medical Center •
University of Maryland Upper Chesapeake Health System – University of Maryland Upper Chesapeake Medical Center -
University of Maryland Harford Memorial Hospital •
University of Maryland Capital Region Health – University of Maryland Bowie Health Center –
University of Maryland Laurel Regional Hospital – University of Maryland Prince George's Hospital Center •
Mt. Washington Pediatric Hospital



250 W. Pratt Street
24th Floor
Baltimore, Maryland 21201-6829
www.umms.org

CORPORATE OFFICE

August 15, 2018

Ben Steffen
Executive Director, Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen:

On behalf of the University of Maryland Medical System (UMMS), I am writing this letter to express support for the Certificate of Need (CON) application filed by Baltimore Nursing and Rehabilitation, LLC (BNR) for a comprehensive care facility (CCF or nursing home) in West Baltimore.

As the state looks to progress to Phase II of the Maryland Demonstration Model, UMMS recognizes the importance of provider collaboration for management of growth in Medicare FFS Total Cost of Care (TCOC). This is particularly important for two of our member hospitals, the University of Maryland Medical Center (UMMC) and the University of Maryland Midtown Campus (UMMC-Midtown), as our West Baltimore community has historically experienced high rates of hospital utilization related to poor health status. While we are currently incented under the Global Budget Revenue (GBR) payment model to reduce avoidable utilization and provide high quality, cost efficient care, we will need to look beyond hospital care if we want to manage TCOC under Phase II.


BNR's application for an 80-bed CCF located at 300 West Fayette Street, located just a mile from UMMC-Midtown, proposes to be "a new kind of nursing home, designed to address the changes in post-acute care created by the Affordable Care Act and the 2014 Maryland Medicare waiver." BNR's vision of post-acute care, in which patients are directly admitted to its facility from hospital emergency rooms or from home, bypassing an acute inpatient stay entirely, is aligned with our goals of addressing health care costs along the entire care spectrum.

On August 2, 2016, the MHCC issued comments on BNR's CON application, stating that "If Mid-Atlantic produces an acceptable signed agreement with UMMC-Midtown and/or other Baltimore City hospitals that fully details both the planned partnership(s) and an appropriate risk-sharing arrangement, staff believes that it may be able to make a positive recommendation on the proposed project, on the basis of advancing more innovative approaches to post-acute care."

In this spirit, UMMS has been working with Mid-Atlantic on the design of a shared-risk construct that will manage Medicare FFS TCOC growth in their shared area. UMMS has submitted a proposal to the Health Services Cost Review Commission (HSCRC) to utilize the HSCRC's Bundled Payments for Care Initiative in Maryland (BPCIM) to share risk on TCOC growth for patients discharged to BNR from UMMS. UMMS anticipates that patients in this Bundle Arrangement will experience superior cost and quality performance compared to patients not included in an episode-based payment system, and that this agreement will generate savings to Medicare and to the state. This enhanced performance will contribute to further reducing Medicare FFS TCOC in West Baltimore City. Further, UMMS will be subject to the Medicare Performance Adjustor ("MPA"), placing it at risk for Medicare FFS TCOC in this region beyond what it is committing to in this Agreement.

The University of Maryland Medical System appreciates the opportunity to comment on the Baltimore Nursing and Rehabilitation proposed project, and looks forward to continued partnership with Mid-Atlantic in innovative care delivery models.

Sincerely,



Henry J. Franey, MBA
Executive Vice President & Chief Financial Officer



Keith D. Persinger
Chief Performance Improvement Officer



CATHERINE PUGH BALTIMORE CITY MAYOR



CATHERINE E. PUGH
MAYOR

*100 Holliday Street, Room 250
Baltimore, Maryland 21202*

June 9, 2017

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Baltimore Nursing and Rehabilitation
Application for CON
Docket No. 15-24-2366

Dear Mr. Steffen,

Baltimore Nursing and Rehabilitation ("BNR"), led by Scott Rifkin, MD and Mid-Atlantic Health Care, is an important project planned for Baltimore City's West side. The project, located at 300 W. Fayette Street, comprises an investment of \$20 million in private funds and creates opportunities for 100 new jobs – both are sorely needed.

As Mayor, I am committed to fostering long-term economic growth and opportunities. And while health care is already an important anchor to the City's economy and job base, it has come to my attention that nearly half of all City residents migrate outside the City for skilled nursing care. Not only does the City lose the jobs and economic activity associated with such out-migration, the City residents placed in nursing facilities and rehab facilities outside

the City are separated from their families and support systems. This is something we can change – and we should change.

Further, the Baltimore Nursing and Rehabilitation project promises to become a vital part of UMMS' and other hospitals' efforts to improve quality of care and control costs of patients after discharge. Given the need for continuous improvement on both fronts, especially in light of the increasing demands on hospitals as a result of the State's Medicare waiver, I am optimistic that BNR will be part of an innovative solution that may be later copied elsewhere.

During my tenure in the State Legislature, I became familiar with the Commission's certificate of need process and its requirements. I am also aware that the request for CON approval for this project has been before the Commission for two years. I encourage you to act quickly to approve the BNR project as it is not only in the best interests of the State's health care system but also of the needs of Baltimore City as a whole.

This project has my strong support. If my office or any of the Agencies of Baltimore City can assist the Commission in making a final decision to approve this project, please do not hesitate to contact Peter Hammen, Chief of Operations at Peter.Hammen@baltimorecity.gov or at 410-396-4903.

Sincerely,

A handwritten signature in black ink, appearing to read "Catherine E. Pugh".

Catherine E. Pugh
Mayor
City of Baltimore

cc: Sam Malhotra, Chief of Staff, Maryland Office of Governor



250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829
www.umms.org

CORPORATE OFFICE

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

May 6, 2016

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

To Whom It May Concern:

I am writing to support the proposed construction of a new comprehensive care facility to be located at 300 W. Fayette Street in downtown Baltimore. The MHCC has asked for more detail about our partnership discussions between Mid-Atlantic Health Care (MAHC) and the University of Maryland Medical Center (UMMC) and the University of Maryland Medical Center Midtown Campus centered on furthering the Maryland Medicare Waiver.

The proposed facility is a major step in our ability to respond to the new realities of Maryland health care as created by the Maryland Medicare Waiver and the Affordable Care Act. First, we are exploring what patient populations are currently served by UMMC that could be discharged sooner into the new facility. The ability to organize care pathways that involved the medical center, the new SNF, and our physicians would be the precursor to creating true bundles under the auspices of the HSCRC. These care pathways would also go a long way toward organizing an approach to decrease hospital readmissions – a major focus of the HSCRC to achieve the goals of the Medicare Waiver. MAHC has an excellent track record of creating care pathways and reducing readmissions in concert with hospital partners.

In addition, we are also analyzing how the facility can aid UMMC in its efforts to lower avoidable admissions as per the Medicare waiver. As that plan develops, we may approach the HSCRC to seek a potential waiver of the three day rule to allow those patients to be directly admitted from the emergency room to the new facility.

Should you have any additional questions, please do not hesitate to contact me at 410-328-1382.

Thank you for your support.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read "Keith D. Persinger".

Keith D. Persinger
Executive Vice President and Chief Operating and Chief Financial Officer, UMMC

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

UNIVERSITY of MARYLAND MEDICAL SYSTEM

University of Maryland Medical Center • University Specialty Hospital
Kernan Orthopaedics and Rehabilitation • Maryland General Hospital • Baltimore Washington Medical Center • Mt. Washington Pediatric Hospital
Shore Health System – Memorial Hospital at Easton • Dorchester General Hospital
Chester River Health System • Civista Medical Center



DEBORAH HAMILTON

LONG TERM CARE OMBUDSMAN

From: Hamilton, Deborah <Deborah.Hamilton@baltimorecity.gov>
Sent: Tuesday, March 29, 2016 11:20 AM
To: Watson, George
Subject: RE: Information on Project at 300 W. Fayette St.

Good Morning,
Thank you for taking the time to speak with me and sending information on the 300 W. Fayette Street project. It appears to be an wonderful collaboration with UMMC Midtown to reduce hospital readmissions through a seamless system of communication and collaboration; such continuity of care always benefits the nursing facility residents.

Deborah

Deborah Hamilton, M.P.A.
Long Term Care Ombudsman Program Manager
BCHD-The Office of Aging & CARE Services
417 E. Fayette Street, 6th FL
Baltimore, MD 21202

Phone: 410-396-3144
FAX: 410-539-0978

Residents' Rights Month is an annual event celebrated in October to honor residents living in all long-term care facilities, including nursing homes, sub-acute units, assisted living, board and care and retirement communities. It is a time for celebration and recognition offering an opportunity for every facility to focus on and celebrate awareness of dignity, respect and the value of each individual resident. The theme for Residents' Rights Month 2015 is, "CARE Matters" with the goal of highlighting quality care.



From: Watson, George [<mailto:GWatson@mid-atlantictlc.com>]
Sent: Tuesday, March 22, 2016 9:23 AM
To: Hamilton, Deborah
Cc: 'Trinkoff, Paul D.'
Subject: Information on Project at 300 W. Fayette St.

Deborah:

It was a pleasure catching up on the phone this am and discussing the project at 300 W. Fayette. I hope you can tell we are very excited about the project and believe it will help provide a new level of care and service to City residents as well as help support Maryland's efforts to support the Medicare Waiver.

CITY OF BALTIMORE

STEPHANIE RAWLINGS-BLAKE, Mayor



HEALTH DEPARTMENT

Leana S. Wen, M.D., M.Sc.
Commissioner of Health
1001 E. Fayette Street
Baltimore, Maryland 21202

October 2, 2015

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Certificate of Need Application for Baltimore Nursing and Rehabilitation, LLC
Docket #15-24-2366

To whom it may concern:

The Baltimore City Health Department is pleased to support Mid-Atlantic Health Care's proposed construction of a new comprehensive care facility to be located at 300-306 West Fayette Street in downtown Baltimore. After learning about Mid-Atlantic and more specifically about the project, we are excited about how this project will help to bring additional, high quality skilled nursing care options to the residents of Baltimore City and particularly to the west side of the city. Currently, 42% of all Baltimore City residents go to Baltimore County for a skilled nursing stay. An additional high-quality option will allow our residents to rehab at a high quality facility closer to home.

Further, the collaboration and integration envisioned between the new facility and the University of Maryland Medical System will not only be unique to Baltimore City, but also the state, and will help supplement Baltimore City's effort support to the Maryland Medicare Waiver. This is especially important as the city's west side has some of the highest per capita hospital spending in the state at \$5,508, vs. the state average of \$2,525.

We hope the Maryland Health Care Commission will look favorably on this application and move quickly to approve the movement of these beds to this new facility.

Sincerely,

Olivia D. Farrow, Esq.
Deputy Commissioner of Health



MAGGIE MCINTOSH
Legislative District 43
Baltimore City

Chair
Appropriations Committee



The Maryland House of Delegates
6 Bladen Street, Room 121
Annapolis, Maryland 21401
410-841-3407 · 301-858-3407
800-492-7122 Ext. 3407
Fax 410-841-3416 · 301-858-3416
Maggie.McIntosh@house.state.md.us

The Maryland House of Delegates

ANNAPOLIS, MARYLAND 21401

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

September 24, 2015

Re: Certificate of Need Application for Baltimore Nursing and Rehabilitation, LLC
Docket #15-24-2366

To whom it may concern:

As a member of the House of Delegates and a resident of Baltimore City, I am writing to express my strong support for the proposed construction of a new comprehensive care facility to be located at 300-306 W. Fayette Street in downtown Baltimore. After learning about Mid-Atlantic - and more specifically about this project - I am excited about how the project will help to bring additional high-quality skilled nursing care options to the residents of Baltimore City, particularly to the Westside. This project will also bring employment and foot traffic to an area that is undergoing a rapid and significant economic transition.

Further, the collaboration and integration envisioned between the new facility and the University of Maryland Medical System (UMMS) will not only be unique to Baltimore City, but also the state, and will help support the Maryland Medicare Waiver.

I hope the MHCC will look favorably on this application and move quickly to approve the movement of these beds to this new and exciting facility.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "M. McIntosh", written over a horizontal line.

Delegate Maggie McIntosh
Chair, Appropriations Committee

September 17, 2015

Re: Mid-Atlantic Health Care, LLC at 300-306 W. Fayette St.

To Whom It May Concern:

On behalf of the Market Center Merchants Association, I am writing to express my support for Mid-Atlantic Health Care, LLC in their efforts to develop a skilled nursing center at the property located at 300-306 W. Fayette Street.

I am confident that Mid-Atlantic will contribute to a productive re-use of this property and will operate a well-run facility that will benefit the neighborhood. This facility, which will be operated in partnership with our strong neighborhood anchor, the University Of Maryland Medical System, will bring needed health care services to West Baltimore and employment and foot traffic to the area which is rapidly undergoing a significant economic transition.

For these reasons, I encourage you to look favorably upon the project and support their request for a zoning ordinance to allow for this use of the property in question. Please don't hesitate to reach out with further question.

Sincerely,



Steven D. Samuelson
President of the Board



Market Center Merchants Association
425 W. Baltimore Street, Baltimore, MD 21201, phone: 410.833.0000 fax: 410.833.6445
www.marketcenterbaltimore.org



Bernard C. "Jack" Young

President

Baltimore City Council

100 N. Holliday Street, Room 400 • Baltimore, Maryland 21202

410-396-4804 • Fax 410-539-0647

E-Mail councilpresident@baltimorecity.gov

**Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215**

September 14, 2015

**Re: Certificate of Need Application for Baltimore Nursing and Rehabilitation, LLC
Docket #15-24-2366**

To whom it may concern:

I am writing to express my strong support for the proposed construction of a new comprehensive care facility to be located at 300-306 W. Fayette Street in downtown Baltimore. After learning about Mid-Atlantic and more specifically about the project, I am excited about how this project will help to bring additional, high quality skilled nursing care options to the residents of Baltimore City and particularly to the Westside. This project will also bring employment and foot traffic to the area which is rapidly undergoing a significant economic transition.

Further, the collaboration and integration envisioned between the new facility and the University of Maryland Medical System (UMMS) will not only be unique to Baltimore City, but also the state, and will help support the Maryland Medicare Waiver.

Given our excitement, we will be submitting and supporting a conditional use zoning variance to allow for the operation of the facility.

I hope the MHCC will look favorably on this application and move quickly to approve the movement of these beds to this new and exciting facility.

Respectfully Submitted,

**Eric T. Costello
Councilman, Baltimore City Council
District 11**

**Bernard C. Young
President, Baltimore City Council**



August 28, 2015

Re: Mid-Atlantic Health Care, LLC at 300-306 W. Fayette Street

To Whom it May Concern:

On behalf of the Downtown Partnership of Baltimore, I am writing to express my support for Mid-Atlantic Health Care, LLC in their bid to develop a skilled senior care facility at the property located at 300-306 W. Fayette Street in Downtown's Bromo Arts & Entertainment District.

I am confident that the Mid-Atlantic Health Care team will contribute to a productive re-use of this property and will operate a well-run care facility. The company's positive track record, including over 15 existing operations in Maryland and Delaware, demonstrates their capacity to succeed in this endeavor.

Furthermore, the use of this property by Mid-Atlantic Health Care to provide quality short-term and long-term care for senior citizens helps to meet a critical need faced by our population. A facility at this location will allow senior citizens from Baltimore City and the surrounding counties to receive healthcare-related treatments and post-hospitalization services in a convenient and well-connected urban setting. The proximity of the Fayette Street property to the University of Maryland Medical Center, located just a few blocks away, provides excellent opportunity for collaboration and continued care, and builds on the strengths that the anchor institution brings to this neighborhood by bringing additional foot traffic and employment to an area that is quickly undergoing a significant economic transition.

With this in mind, I encourage you to look favorably upon Mid-Atlantic Health Care's plans for development in Downtown and support their request for a zoning ordinance to allow for this use at the property in question. Please don't hesitate to reach out with any further questions.

Sincerely,

Kirby Fowler,
President

August 12, 2015

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

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

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

To Whom It May Concern:

I am writing to follow up on my previous letter of support dated April 10, 2015 for the proposed construction of a new comprehensive care facility to be located at 300 W. Fayette Street in downtown Baltimore. The MHCC has asked for more detail about our partnership discussions between Mid-Atlantic Health Care (MAHC) and UMMC Midtown Campus centered on furthering the Maryland Medicare Waiver.

The proposed facility is a major step in our ability to respond to the new realities of Maryland health care as created by the Maryland Medicare Waiver and the Affordable Care Act. First, we are exploring what patient populations are currently served by UMMC Midtown Campus that could be discharged sooner into the new facility. The ability to organize care pathways that involved the medical center, the new SNF, and our physicians would be the precursor to creating true bundles under the auspices of the HSCRC. These care pathways would also go a long way toward organizing an approach to decrease hospital readmissions – a major focus of the HSCRC to achieve the goals of the Medicare Waiver. MAHC has an excellent track record of creating care pathways and reducing readmissions in concert with hospital partners.

In addition, we are also analyzing how the facility can aid UMMC Midtown Campus in its efforts to lower avoidable admissions as per the Medicare waiver. As that plan develops, we may approach the HSCRC to seek a potential waiver of the three-day rule to allow those patients to be directly admitted from the emergency room to the new facility.

I hope this provides more clarity into some of our discussions. Please feel free to contact me with any additional questions.

Sincerely,



Brian G. Bailey
Sr. VP, Executive Director

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

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

May 19, 2015

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

To whom it may concern:

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

I am writing to express my strong support for the proposed construction of a new comprehensive care facility currently expected to be located at 300 W. Fayette Street in downtown Baltimore. I have had several discussions with Dr. Scott Rifkin, CEO of Mid-Atlantic Health Care, LLC, about the project and am excited about continuing to explore the opportunity to partner with Mid-Atlantic to develop a truly novel approach to help avoiding hospitalizations and lowering hospital re-admissions via a state of the art post-acute care center.

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

Respectfully Submitted,



Brian G. Bailey

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

EXHIBIT F

GROUND LEASE OPTION AGREEMENT

THIS GROUND LEASE OPTION AGREEMENT (this “**Agreement**”) is made effective as of February 14, 2019 (the “**Effective Date**”), by and between Maryland General Hospital, Inc. (d/b/a University of Maryland Medical Center Midtown Campus), a Maryland corporation (“**Owner**”) and Mid-Atlantic Healthcare Acquisitions, LLC, a Maryland limited liability partnership or its designee (“**Tenant**”). Owner and Tenant may hereinafter be referred to individually as a “**Party**” and collectively as the “**Parties**”.

EXPLANATORY STATEMENTS

A. Owner is the fee simple record and beneficial owner of that certain property and improvements thereon located at and commonly known as 300 Armory Place, Baltimore, Maryland 21201 (the “**Property**”).

B. Owner and Tenant intend to demolish the current improvements located on the Property and to re-develop the Property and construct an approximately 105,000 square foot building (the “**New Building**”) consisting of approximately (i) 60,000 square feet of rentable space dedicated to skilled nursing and post-acute care residential rooms and associated facilities (the “**SNF Premises**”), and (ii) 45,000 square feet of rentable space dedicated as medical office building space (the “**MOB Premises**”).

C. Tenant is currently in the process of applying for a Certificate of Need (a “**CON**”) from the Maryland Health Care Commission (the “**MHCC**”) in order to become licensed to operate skilled nursing and post-acute beds at the SNF Premises.

D. If Tenant’s CON is approved by the MHCC, Owner desires to grant to Tenant the option to enter into a ground lease with respect to the Property pursuant to which Tenant (or its affiliate) will (i) demolish, or cause the demolition of, the existing improvements on the Property, (ii) construct, or cause the construction of, the New Building, (iv) occupy and operate the SNF Premises as a skilled nursing and post-acute care facility, and (v) lease the MOB Premises to Owner [**and other physicians and healthcare providers**] for use as a medical office building.

AGREEMENT

NOW, THEREFORE, in exchange for the payment of \$1,000 from Tenant to Owner, and for other good and valuable consideration, the receipt, sufficiency, and fairness of which are hereby acknowledged, and intending to be legally bound, Owner and Tenant, for themselves and their respective successors and permitted designees and assigns, hereby covenant and agree as follows:

1. Ground Lease Option.

(a) Grant of Option. Subject to the conditions set forth herein, Owner hereby grants to Tenant the exclusive right and option (the “**Option**”) to ground lease the Property from Owner. Tenant has the right to exercise the Option at any time between (the “**Option Period**”)

the date that the CON is issued to Tenant (or its affiliate) by the MHCC and March 31, 2020 (the “**Option Termination Date**”). The Option may be exercised (i) at any time after Tenant is awarded a CON with respect to the Property; and (ii) by Tenant in writing delivered to Owner at the address set forth in this Agreement (the date of delivery of the Option is hereinafter referred to as the “**Option Exercise Date**”).

(b) Exercise of Option; Ground Lease Terms. Upon the exercise of the Option, Tenant and Owner shall negotiate the terms and conditions of the ground lease (the “**Ground Lease**”) in good faith for a period of not longer than 120 days after the Option Exercise Date. The terms and conditions of the Ground Lease will be subject to the approval of the Board of Trustees or other governing body of the Owner, but will contain the following general terms and conditions:

(i) Tenant (or its designee) shall pay all its own costs related to the negotiation of the Ground Lease;

(ii) Tenant (or its designee) shall pay all costs related to obtaining any environmental assessment reports, surveys, and title insurance that the Tenant (or its designee) desires to obtain;

(iii) Tenant (or its designee) shall be responsible for all realty transfer and recording taxes, fees, assessments or charges in connection with entering into the Ground Lease and/or the recording of the Ground Lease;

(iv) all other fees, costs, expenses and charges shall be paid by the party customarily charged for such fees, costs, expenses and charges in the jurisdiction where the Property is located;

(v) the term of the Ground Lease will be for a period of 50 years, with two 10 year renewal options exercisable in writing by Tenant (or its designee) not later than 60 days prior the expiration of the then-current term or renewal term;

(vi) the annual rental payment for the Property will be the Fair Market Rent (as defined herein) per square foot;

(vii) Owner will have the right to approve (acting in good faith and subject to its reasonable discretion) all designs and site plans related to the construction of the New Building, which approval will not be unreasonably withheld, conditioned or delayed; and

(viii) Owner shall promptly provide any certificates or other documents that are reasonably requested by Tenant (or its designee), or otherwise reasonably required to consummate the Tenant’s (or its designee’s) lease of the Property, including, without limitation, Owner’s organizational/authorization documents and affidavits sufficient to cause the title company to omit all standard or preprinted exceptions to any title insurance policy issued for the Property or required in connection with any zoning or other regulatory approvals necessary in connection with the Ground Lease.

(c) MOB Lease. Upon the exercise of the Option, Tenant and Owner shall negotiate the terms and conditions of a commercial lease for the MOB Premises (the “**MOB Lease**”) in good faith for a period of not longer than 120 days after the Option Exercise Date. The MOB Lease shall contain such terms and conditions as are typically contained in commercial leases for medical office space, and such other terms and conditions as the Parties may mutually agree.

(d) Determination of Fair Market Rent. The “**Fair Market Rent**” per square foot will be equal to an amount mutually agreed upon between Tenant (or its designee) and Owner or, if Tenant (or its designee) and Owner are unable to agree on an amount within 120 days after the date of the Option Notice, then an amount determined by an independent real estate appraiser mutually selected by Owner and Tenant (and if Owner and Tenant cannot mutually agree upon an independent real estate appraiser, then the independent real estate appraiser will be mutually selected by representatives of the real estate appraisers selected by each of Owner and Tenant). Any real estate appraiser selected pursuant to this Agreement shall possess the MAI designation from the Appraisal Institute and have at least ten (10) years of experience in the valuation and leasing of healthcare facilities and other real property whose predominate use relates to the provision of healthcare services. The real estate appraiser shall utilize the Uniform Standards of Appraisal Practice (including the Competency Provision) established by the Appraisal Institute. The Fair Market Rent shall be determined for the Property as an unimproved and unencumbered parcel in the location where the Property is situated, and not as an ongoing business, and shall account for Tenant’s cost incurred in demolishing, or causing to be demolished, the improvements existing on the Property as of the date of this Agreement. The Fair Market Rent shall be determined for the MOB Premises as improved and new medical office building space in the location where the Property is situated. The Parties will select the real estate appraiser within 150 days after the date of the Option Notice, and the real estate appraiser shall determine the Fair Market Rent within 30 days after its appointment. The determination of the Fair Market Rent by the real estate appraiser shall be final, conclusive, and binding upon the Parties. The Parties will share equally in the cost of and expenses incurred by the real estate appraiser.

(e) Exclusivity. During the period between the date of this Agreement and the Option Termination Date, Owner will not sell, transfer, convey, lease, ground lease, license or otherwise allow the occupancy of the Property by any other person, nor enter into any contract, agreement, understanding or arrangement with respect to any of the foregoing.

2. Expenses. Except as otherwise provided in this Agreement, Tenant and Owner shall each pay their own fees, expenses and disbursements, including the fees and expenses of their respective counsel, accountants, and other experts in connection with the subject matter of this Agreement and all other costs and expenses incurred in performing and complying with all conditions to be performed under this Agreement.

3. Waivers. The waiver by any Party of a breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach.

4. Binding Effect; Benefits. This Agreement shall inure to the benefit of the Parties, and shall be binding upon the Parties and their respective successors, assigns, heirs, executors, administrators and legal representatives. Unless specifically set forth herein, nothing in this Agreement, express or implied, is intended to confer on any person other than the Parties,

or their respective successors, assigns, heirs, executors, administrators and legal representatives, any rights, remedies, obligations or liabilities under or by reason of this Agreement.

5. Notices. All notices, requests, demands, elections and other communications which any Party may be required to give hereunder shall be in writing and shall be deemed to have been duly given if delivered personally, by a reputable courier service which requires a signature upon delivery, or by mailing the same by registered or certified first class mail, postage prepaid, return receipt requested on the date of such receipt, to the Party to whom the same is so given or made. Such notice, request, demand, waiver, election or other communication will be deemed to have been given as of the date so delivered or refused.

Notice to Owner: University of Maryland Medical Center Midtown Campus
827 Linden Avenue
Baltimore, MD 21201
Attn: President

With a copy to: University of Maryland Medical System Corporation
250 W. Pratt Street, 24th Floor
Baltimore, MD 21201
Attn: General Counsel

If to the Tenant, to: Mid-Atlantic Healthcare Acquisitions, LLC
8501 LaSalle Road, Suite 303
Towson, MD 21286
Attn: Scott Potter and George Watson

With a required copy to: Miles & Stockbridge P.C.
100 Light Street
Baltimore, MD 21202
Attn: Joseph P. Ward

6. Counterparts. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument. A facsimile, electronic or similar reproduction of a signature by one or both of the Parties shall be treated as an execution in writing for purposes of this execution of this Agreement.

7. Headings. The article, section and other headings contained in this Agreement are for reference purposes only and shall not be deemed to be a part of this Agreement or to affect the meaning or interpretation of this Agreement.

8. Construction. Within this Agreement, the singular shall include the plural and the plural shall include the singular, and any gender shall include all other genders, all as the meaning and the context of this Agreement shall require.

9. **Governing Law, Jurisdiction, and Venue.** This Agreement shall be governed by and construed in accordance with the laws of the State of Maryland applicable to contracts executed and performed in such state, without giving effect to conflicts of laws principles. The proper venue for the adjudication of any disputes arising hereunder shall be in front of any state or federal court sitting in Baltimore City, Maryland, and the Parties irrevocably consent to the jurisdiction thereof.

10. **Cooperation.** The Parties shall cooperate fully at their own expense, except as otherwise provided in this Agreement, with each other and their respective counsel and accountants in connection with all steps to be taken as part of their obligations under this Agreement.

11. **Severability.** If any term, covenant, condition or provision of this Agreement or the application thereof to any circumstance shall be invalid or unenforceable to any extent, the remaining terms, covenants, conditions and provisions of this Agreement shall not be affected thereby and each remaining term, covenant, condition and provision of this Agreement shall be valid and shall be enforceable to the fullest extent permitted by law; provided, however, that the Parties shall continue to achieve their respective substantial purpose in entering into this Agreement. If any provision of this Agreement is so broad as to be unenforceable, such provision shall be interpreted to be only as broad as is enforceable.

12. **Successors and Assigns.** The covenants, agreements, and conditions contained herein or granted hereby shall be binding upon and shall inure to the benefit of Owner and Tenant, and each of their respective permitted successors, assigns, heirs, executors, administrators and legal representatives. Neither Party shall assign, or otherwise transfer any interest in this Agreement to any other person without the prior written consent of the other party, which consent shall not unreasonably be withheld; provided that Tenant may transfer and assign its rights under the Agreement to a designee who is an affiliate of Tenant by virtue of common ownership.

13. **Drafting.** No provision of this Agreement shall be interpreted for or against either Party on the basis that such Party was the drafter of such provision, each Party having participated equally in the drafting hereof, and no presumption or burden of proof shall arise favoring or disfavoring any Party by virtue of the authorship of any of the provisions of this Agreement.

14. **Recording.** Owner hereby agrees that Tenant, at Tenant's sole cost and expense, may record among the land records for the City of Baltimore related to the Property (i) this Agreement, and (ii) upon exercise of the Option, a Memorandum of Ground Lease.

15. **Entire Agreement.** This Agreement constitutes the entire agreement and understanding between the Parties as to the matters set forth herein and supersede and revoke all prior agreements and understandings, oral and written, between the Parties or otherwise with respect to the subject matter hereof or thereof. No change, amendment, termination or attempted waiver of any of the provisions hereof or thereof shall be binding upon any Party unless set forth


in an instrument in writing signed by the Party to be bound or their respective successors in interest.

[Signatures on the following page]

IN WITNESS WHEREOF, the undersigned has executed this Agreement the day and year first written above.

OWNER:

Maryland General Hospital, Inc.
d/b/a University of Maryland Medical Center
Midtown Campus, a Maryland corporation

By: 
Alison G. Brown
President

[Signatures continue and end on the following page]

TENANT:

MID-ATLANTIC HEALTHCARE ACQUISITIONS, LLC,
a Maryland limited liability company

By: 
Name: Scott Rifkin
Title: Manager

EXHIBIT G



Baltimore Nursing and Rehab
Baltimore, Maryland

MASSING

December 14, 2018



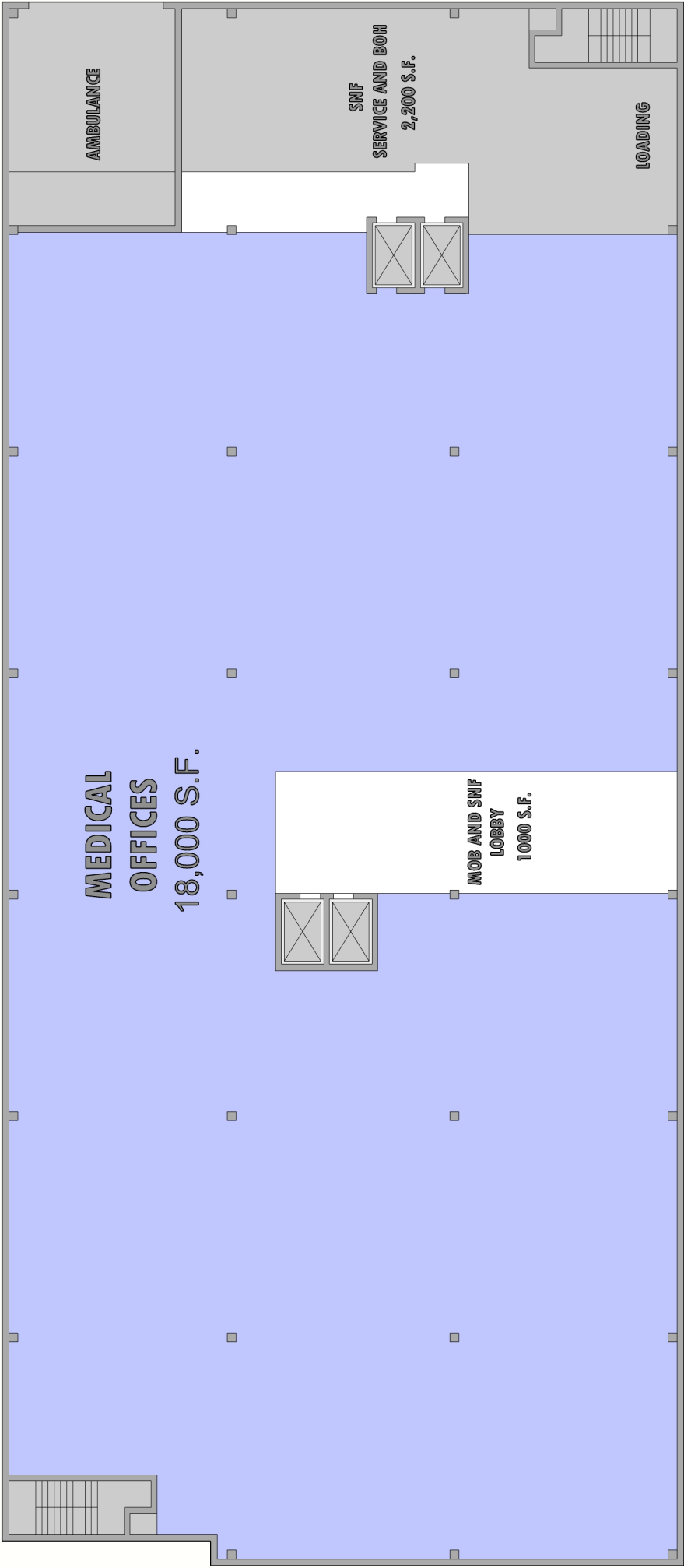
Baltimore Nursing and Rehab
Baltimore, Maryland

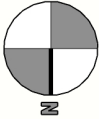
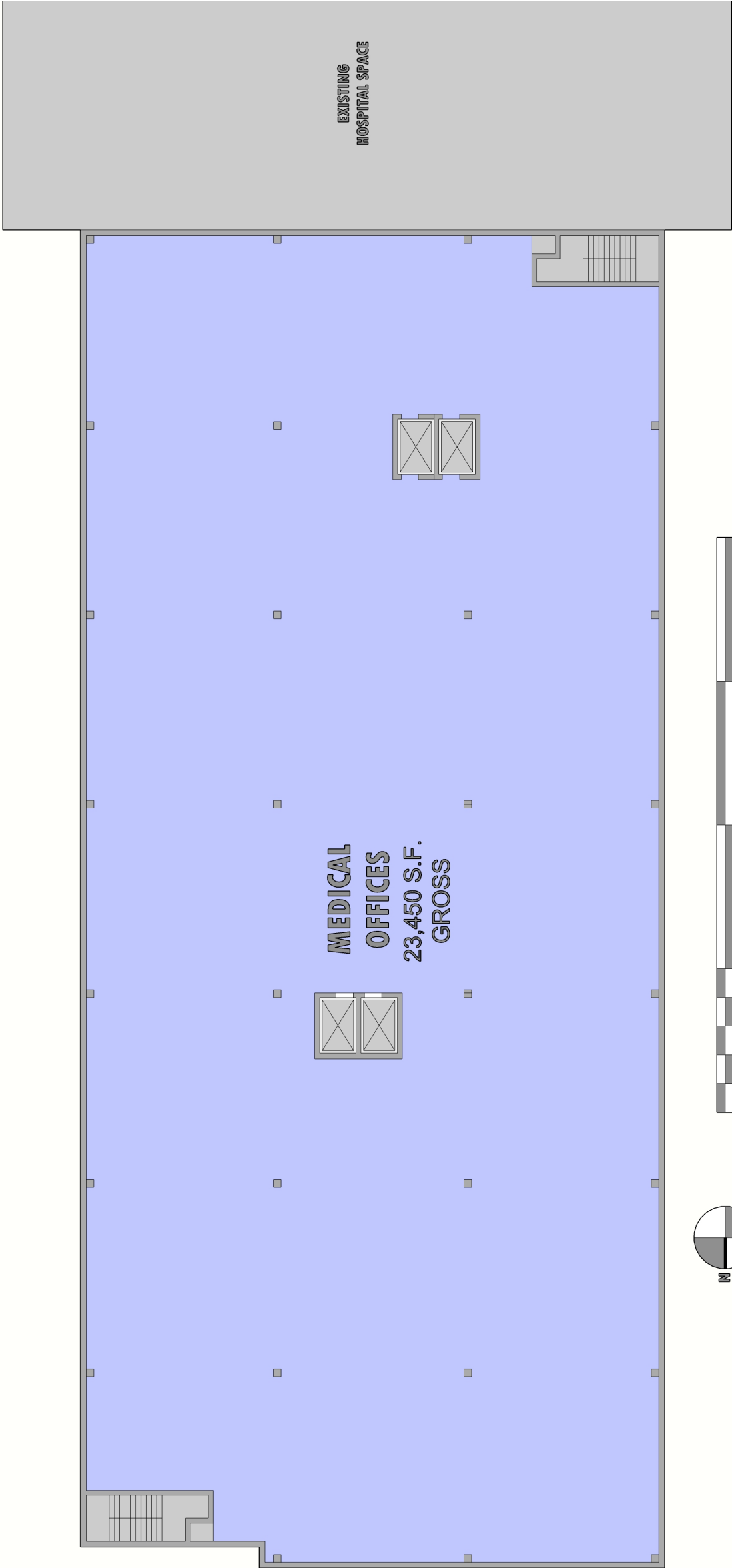
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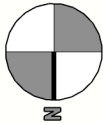
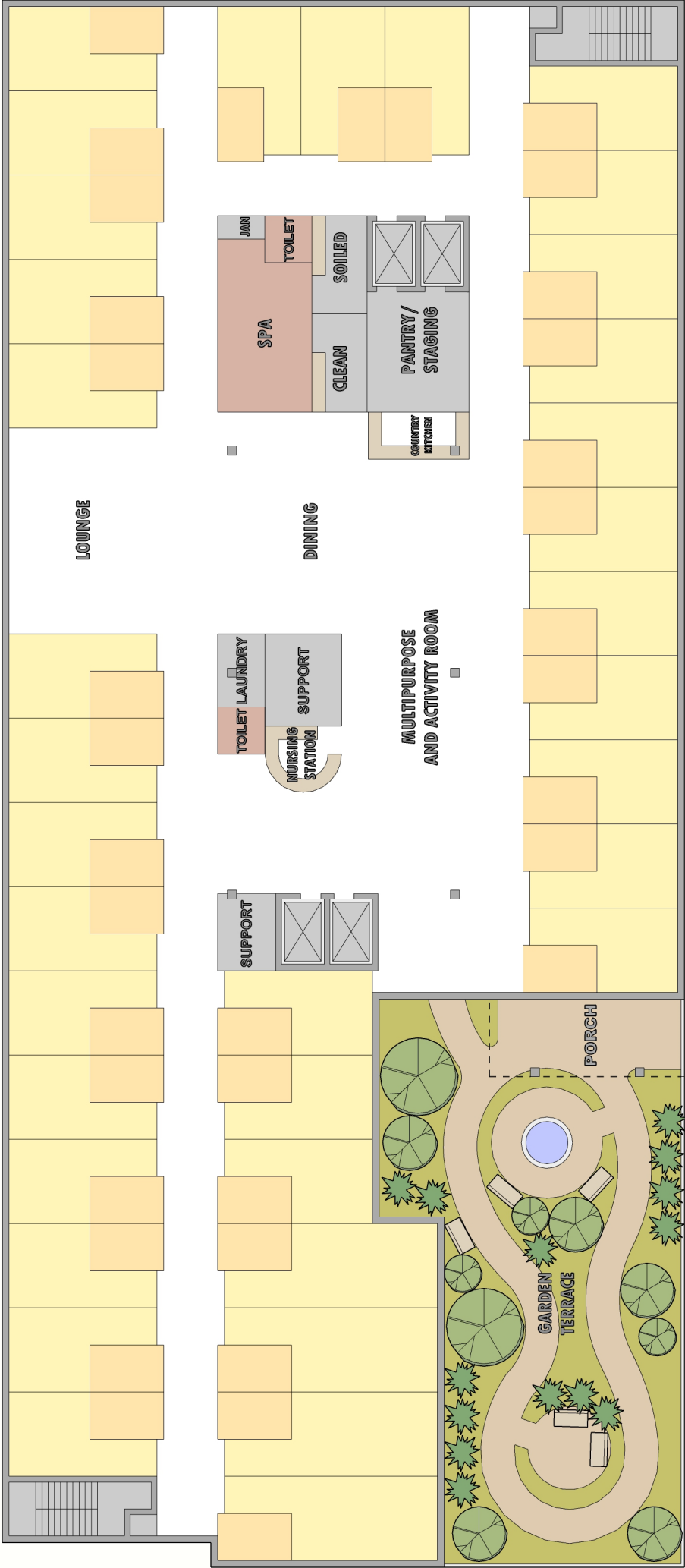
December 14, 2018

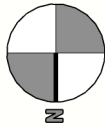
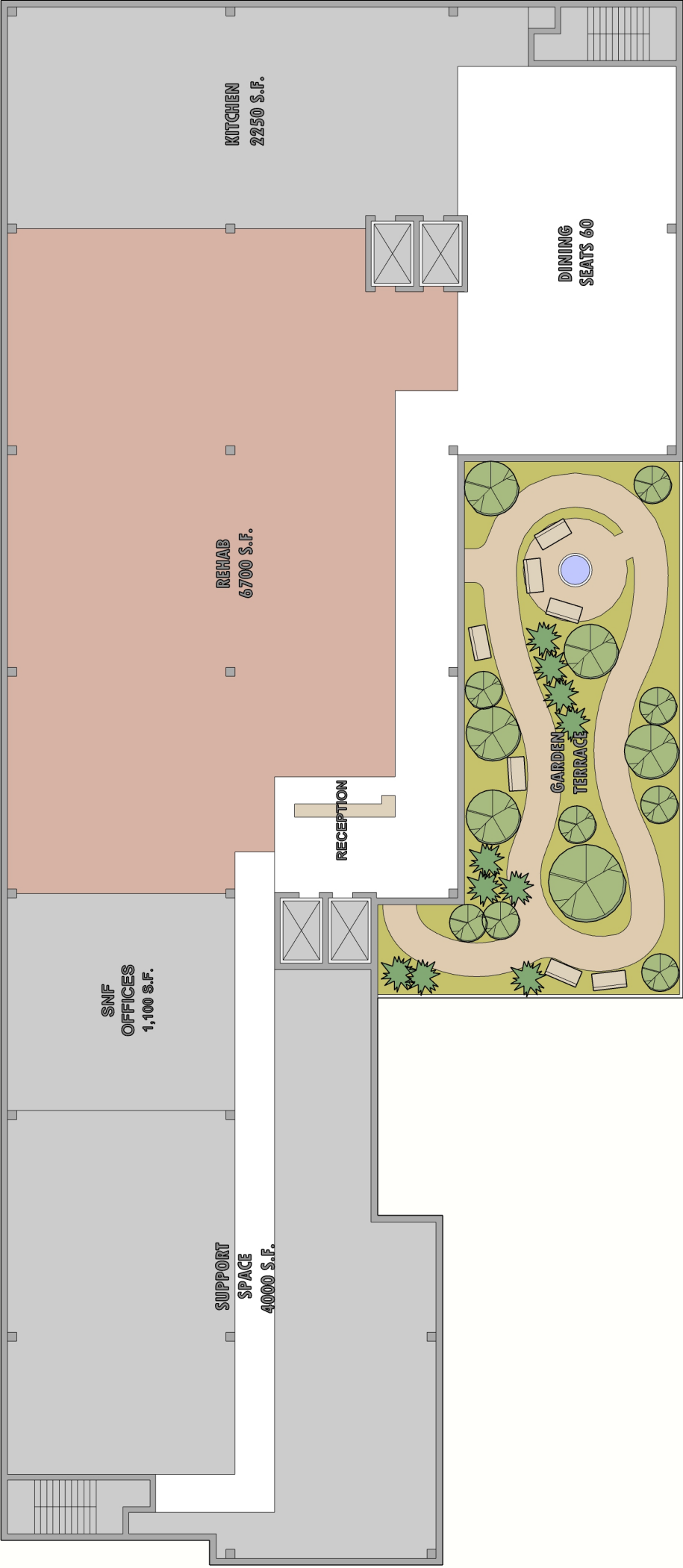


TOTAL SNF SQUARE FOOTAGE :	59,850 S.F.
80 BEDS / 59,850 S.F. :	748 S.F. PER BED
TOTAL MEDICAL OFFICE S.F.	41,450 S.F.
TOTAL GROSS SQUARE FOOTAGE :	103,700 S.F.









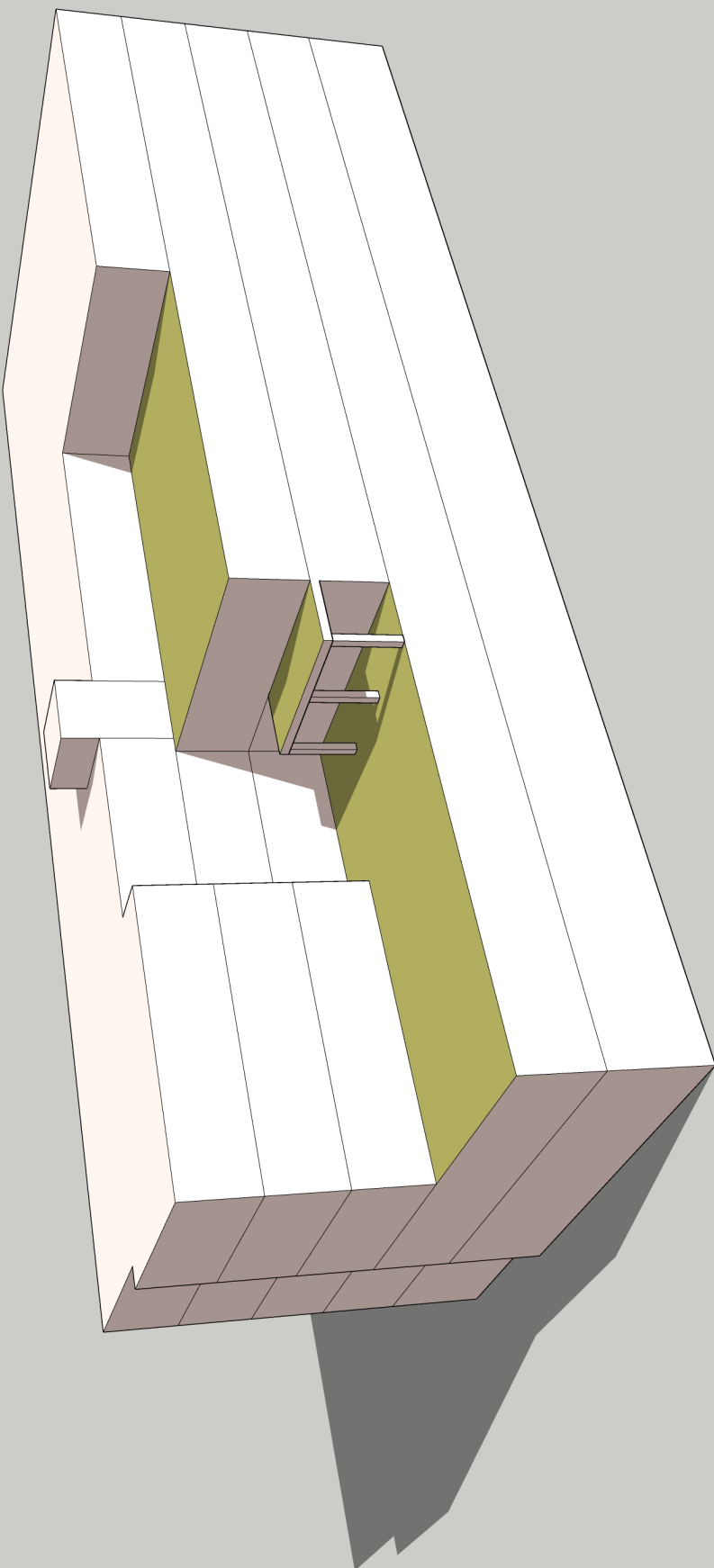


EXHIBIT H

Attachment H: Projection Assumptions

The Applicant has used its experience formerly operating 22 skilled nursing facilities (and now two) to develop its financial projections with a particular focus of one its facilities in Maryland that has a similar expected payor mix and clinical focus.

Assumed Opening & Pre-Opening Expenses

The projections begin in March 2021, to cover the pre-opening labor expenses assumed as construction is completing and the facility gears up for admitting patients. This period is expected to last 4 months with the facility opening and admitting residents starting July 1, 2021. The pre-opening expenses include costs associated for the following positions:

March 2021	April 2021	May 2021	June 2021
<ul style="list-style-type: none">• Administrator	<ul style="list-style-type: none">• Human Resources• Maintenance Manager	<ul style="list-style-type: none">• Director of Nursing• Food Service Manager• Housekeeping Supervisor• Housekeeping Staff• Admissions	<ul style="list-style-type: none">• Assistant Director Of Nursing• Nurse Liaison• MDS Coordinator• Central Supply• Social Service Director• Activities Director• Cooks & Cooks Helpers• Laundry• Billing

Census / Volume Growth

The projections assume the first residents are admitted to the facility July 1, 2021. To drive our census assumptions we have split admissions between short stay and long stay residents.

Short Stay Residents:

- Aggressive return to home rehab
- LVAD
- Vent units
- Cardiac Patients
- Short term observation stays
- Palliative care

Long Stay Residents:

- Dialysis
- Bariatric

- Other typical comprehensive care patients
- Longer term rehabilitation

Another key assumption is the payor mix at the facility. We have modeled our payor mix to be similar to Fairfield, one of our former MD-based facilities that has a similar resident mix and is a similar size (96 beds). As mentioned elsewhere in the application, we have assumed we will maintain a 47.01% census for Medicaid which is the average of all the nursing homes in the jurisdiction within which the Facility operates. Beyond that, given the focus on aggressive return to home rehabilitation residents and other more acute conditions, we estimate a high percentage (42%) of census to come from Medicare. This is a similar percentage as Fairfield. The remaining split of 11% is split between private pay (5%) and commercial insurance (6%).

Projected Reimbursement Rates

The Applicant has assumed rates based on calculations of its Reimbursement Director and by using rates at another of its MD-based facility with a similar patient mix. MAHC's reimbursement consultant has established the expected Medicaid reimbursement rate by assuming a case mix index and then applying the Maryland pricing methodology. Given the Company's and this specific facilities focus on higher acuity patients, the Applicant used a CMI of 1.09 in year 1 and 1.20 on year 2. These compare to the state average of 1.07 and a Mid-Atlantic average of 1.22. With these assumptions, the Applicant estimates its Medicaid reimbursement to be \$275.12 during the first 12 months and then 1.20 for the remainder of the projection period.

We have used rates similar to our other facilities for other rates:

Medicare Part A	\$534.10
Private	\$290.00
Managed Care	\$300.00
Medicare Part B	\$10.00

Non-operating Income - Rental Income

The CCF will comprise primarily floors 3 – 5. That leaves approximately 40,750 square feet for medical office tenants. For sakes of the projections we have assumed we have assumed we lease out the floors 1 & 2. We have used rental rates as provided to us by commercial real estate brokers who estimate the space could rent for \$25 per square foot. We assumed a 5% vacancy rate and netted it against property management costs at 3% of rents. This yields the following rental income stream recorded as non-operating income since it is separate from the facility.

	2021	2022	2023	2024	2025
Rent Income	\$468,625	\$974,420	\$1,003,653	\$1,033,762	\$1,064,775

Expense Assumptions

Expense assumptions have been built on a detailed line item basis based on per diem rates and totals from other Mid-Atlantic facilities. We have broken out our expense items into more detail as follows:

	2021	2022	2023	2024	2025
	Total	Total	Total	Total	Total
Salaries & Wages					
Nursing Services	\$ 1,061,917	\$ 2,662,500	\$ 2,715,013	\$ 2,715,013	\$ 2,715,013
Nursing Services Benefits	223,595	662,341	673,587	673,587	673,587
Other Patient Care	84,753	182,032	182,032	182,032	182,032
Other Patient Care Benefits	17,798	45,283	46,052	46,052	46,052
Routine Services	262,757	544,560	544,560	544,560	544,560
Routine Services Benefits	54,980	135,468	137,768	137,768	137,768
Administrative	240,600	351,200	351,200	351,200	351,200
Administrative Benefits	52,187	100,304	102,549	102,549	102,549
Total Salaries, Wages & Benefits	<u>\$ 1,998,586</u>	<u>\$ 4,683,688</u>	<u>\$ 4,752,761</u>	<u>\$ 4,752,761</u>	<u>\$ 4,752,761</u>
Contractual Services					
Therapy					
Medical Director	327,241	1,451,059	1,514,148	1,514,148	1,514,148
Psychiatrist	15,000	30,000	30,000	30,000	30,000
Total	<u>5,000</u>	<u>10,000</u>	<u>10,000</u>	<u>10,000</u>	<u>10,000</u>
	347,241	1,491,059	1,554,148	1,554,148	1,554,148
Other expenses					
Nursing Services	\$ 34,347	\$ 157,896	\$ 164,761	\$ 164,761	\$ 164,761
Other Patient Care	143,988	616,425	679,123	679,123	679,123
Routine Services	215,863	704,608	751,211	751,211	751,211
Administrative	123,323	332,342	362,322	361,364	360,707
Management Fee	102,082	493,251	523,359	523,359	523,359
Capital/Property	38,475	225,009	238,313	238,313	238,313
Capital Rental	-	-	-	-	-
Total Other Expenses	<u>\$ 658,077</u>	<u>\$ 2,529,531</u>	<u>\$ 2,719,090</u>	<u>\$ 2,718,133</u>	<u>\$ 2,717,475</u>

EXHIBIT I

Mid-Atlantic Health Care

Facility Listing

Facility Name	Beds	Address	City	State
Formerly Owned Portfolio				
Berlin Nursing and Rehabilitation Center	165	9715 Healthway Drive	Berlin	MD
Oakland Nursing & Rehabilitation Center	100	706 East Alder Street	Oakland	MD
Fairfield Nursing & Rehabilitation Center	96	1454 Fairfield Loop Road	Crownsville	MD
Mid-Atlantic Of Chapel Hill, LLC	63	4511 Robosson Road	Randallstown	MD
Allegany Health Nursing and Rehab	153	730 Furnace Street	Cumberland	MD
Villa Rosa Nursing and Rehabilitation	107	3800 Lottsford Vista Road	Mitchellville	MD
Forest Haven Nursing	167	701 Edmondson Ave	Catonsville	MD
Restore Health Rehabilitation Center	67	4615 Einstein Place	White Plains	MD
Northampton Manor	196	200 E. 16th Street	Frederick	MD
Julia Manor	131	333 Mill Street	Hagerstown	MD
Devlin Manor	124	10301 Christie Rd. NE	Cumberland	MD
Moran Manor	120	25701 Shady Lane SW	Westernport	MD
Falling Spring Nursing and Rehab	186	201 Franklin Farm Lane	Chambersburg	PA
Care Pavilion Nursing and Rehabilitation Center	396	6212 Walnut Street	Philadelphia	PA
York Nursing Home	240	7101 Old York Road	Oak Lane	PA
Cliveden Nursing and Rehabilitation Center	180	6400 Greene Street	Philadelphia	PA
Maplewood Nursing and Rehab Center	180	125 W Schoolhouse Lane	Philadelphia	PA
Tucker House Nursing and Rehabilitation Center	180	1001-11 Wallace Street	Philadelphia	PA
Milton Nursing and Rehabilitation Center	138	743 Mahoning Street	Milton	PA
Watsonstown Nursing and Rehabilitation Center ⁽¹⁾	115	245 East Eight Street	Watsonstown	PA
Parkhouse Nursing and Rehabilitation Center	467	1600 Black Rock Road	Royersford	PA
Formerly Owned Portfolio	3,571			
Currently Owned				
Shippensburg Health Care Center	125	121 Walnut Bottom Road	Shippensburg	PA
Restore Health at University City	124	3609 Chesnut Street	Philadelphia	PA
Total Currently Owned	249			

EXHIBIT J

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3413



Northeast Division of Survey & Certification

July 22, 2013

Mr. Robert Lanzo, Administrator
Delmar Nursing & Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940

CMS Certification Number: 085041

DENIAL OF PAYMENT - PLEASE READ CAREFULLY

Dear Mr. Lanzo:

After a careful review of the facts, the Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), has determined that Delmar Nursing & Rehabilitation Center no longer meets the requirements for participation as a provider of services in the Health Insurance Program for the Aged and Disabled (Medicare) established under Title XVIII of the Social Security Act (the Act), and Medicaid, Title XIX of the Act.

To participate in the Medicare program as a provider of skilled nursing facility services, a facility must meet all of the provisions of Section 1819 (b), (c), and (d) of the Act. In addition, a skilled nursing facility must be in compliance with the Requirements for Long Term Care Facilities established by the Secretary of Health and Human Services, and be free of hazards to the health and safety of residents. If that facility participates in the Medicaid program, it must also meet all of the provisions of Sections 1919 (b), (c), and (d) of the Act.

On May 10, 2013, an abbreviated survey was completed at your facility by the Delaware Department of Health and Social Services (State survey agency) to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. That survey found that your facility was not in substantial compliance with the participation requirements.

Although a revisit has not been completed at your facility we are denying Medicare and Medicaid payment for all new admissions to your facility effective August 10, 2013. This action is required by sections 1819 (h)(2)(B)(i), 1819 (h)(2)(D), 1919 (h)(3)(B)(ii), and 1919 (h)(3)(C)(i) of the Social Security Act. **If a revisit is completed which finds that your facility regained compliance prior to August 10, 2013 this action will be withdrawn.** In addition, you are advised that, should you remain out of compliance, your provider agreement will be terminated on November 10, 2013. **Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions.**

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health & Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR 498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen Robinson, Division Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy of that appeal to:

Mr. James C. Newman, Chief Counsel
Office of the General Counsel
Public Ledger Building, Suite 418
150 South Independence Mall West
Philadelphia, PA 19106

Should we take action to terminate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights are separate and distinct from the appeal rights cited above.

You will be notified separately by the Delaware State Medicaid agency regarding their application of the remedies in this letter.

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

Sincerely,

Timothy J. Hock, Manager
Certification and Enforcement Branch



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF
MEDICAID & MEDICAL ASSISTANCE

OFFICE OF THE DIRECTOR

July 23, 2013

Mr. Robert Lanzo, Administrator
Delmar Nursing & Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940

CMS Certification Number: 085041

DENIAL OF PAYMENT - PLEASE READ CAREFULLY

Dear Mr. Lanzo:

Based on the July 22, 2013 letter sent to you by Mr. Timothy J. Hock, Certification and Enforcement Branch of CMS, the Delaware Division Medicaid & Medical Assistance hereby notifies you that the following two actions will ensue.

- Delaware Medicaid will deny payments for all new Medicaid admissions effective August 10, 2013. This means that Medicaid vendor payments for Delaware Medicaid patients admitted to your facility from August 10, 2013 forward will not be honored.
- Your Delaware Medicaid contract will be terminated no later than November 10, 2013.

These actions are mandated by the Code of Federal Regulations 42, Part 30 to End - Part 442, Subpart B - Provider Agreement, 442.12 which states "... **a Medicaid agency may not execute a provider agreement with a facility for nursing facility services nor make Medicaid payment to a facility for those services unless the Secretary or the State Survey agency has certified the facility under this part to provide those services.**"

This notice results from the findings of the Division of Long Term Care Residents Protection that your facility is not in substantial compliance with Federal participation requirements and State regulations. Evidence upon which this decision was based was enclosed in the letter that Mr. Hock sent to you. If an acceptable Plan of Correction is submitted to Mr. Hock within the time frame mandated by him, and if he finds that substantial compliance has been achieved, this action will be stayed.

Mr. Robert Lanzo
July 23, 2013
Page Two

If this action is not stayed, Delaware Medicaid will either-

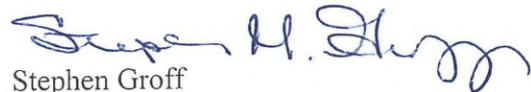
- work with your facility to find alternate placements for our Medicaid patients in the case of termination, and/or –
- work with CMS, and/or the Division of Long Term Care Residents Protection in the imposition and implementation of remedies specified by them.

Mr. Hock's letter to you specified the remedy/ies that will be imposed if substantial compliance is not achieved. Note that the enforcement action(s) may be revised if there is a change in the seriousness of noncompliance.

In accordance with 42 CFR 498.40, your facility may request a hearing before an Administrative Law Judge. This request should be made per the procedures outlined in Mr. Hock's letter to you.

If you have any questions, please feel free to call me.

Sincerely,



Stephen Groff
Director
Division of Medicaid & Medical Assistance

pc: Robert Smith

SG: gr

SETTLEMENT AGREEMENT

I. Recitals

1. Parties. The Parties to this Settlement Agreement (Agreement) are the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) and Mid-Atlantic of Delmar, LLC (Respondent).

2. Factual Background and Covered Conduct. The OIG contends that from October 18, 2013 through May 30, 2014, Respondent employed Douglas Entenman (DE) for the provision of items or services for which payment may be made under a Federal health care program. On June 7, 2014, Respondent made a submission pursuant to OIG's Self Disclosure Protocol (Protocol), and OIG accepted Respondent into the Protocol on July 23, 2014. The OIG contends that Respondent knew or should have known that DE was excluded from participation in all Federal health care programs and that no Federal health care program payments could be made for items or services furnished by DE. The OIG contends that the conduct described in this Paragraph (hereinafter referred to as the "Covered Conduct") subjects Respondent to civil monetary penalties, assessments, and exclusion under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7).

3. No Admission or Concession. This Agreement is neither an admission of liability by Respondent nor a concession by the OIG that its claims are not well-founded.

4. Intention of Parties to Effect Settlement. In order to avoid the uncertainty and expense of litigation, the Parties agree to resolve this matter according to the Terms and Conditions of this Agreement.

II. Terms and Conditions

5. Payment. Respondent agrees to pay to OIG \$92,344.60 (Settlement Amount). This payment shall be made via wire transfer to the United States Department of Health and Human Services according to written instructions provided by OIG. Respondent shall make full payment no later than three business days after the Effective Date.

6. Release by the OIG. In consideration of the obligations of Respondent under this Agreement and conditioned upon Respondent's full payment of the Settlement Amount, the OIG releases Respondent from any claims or causes of action it may have against Respondent under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7) for the Covered Conduct. The OIG and HHS do not agree to waive any rights, obligations, or causes of action other than those specifically referred to in this Paragraph. This release is applicable only to Respondent and is not applicable in any manner to any other individual, partnership, corporation, or entity.

7. Agreement by Respondent. Respondent shall not contest the Settlement Amount under this Agreement or any other remedy agreed to under this Agreement. Respondent waives all procedural rights granted under the exclusion statute (42 U.S.C. § 1320a-7), the CMPL (42 U.S.C. § 1320a-7a) and related regulations (42 C.F.R. Part 1003), and HHS claims collection regulations (45 C.F.R. Part 30), including, but not limited to, notice, hearing, and appeal with respect to the Settlement Amount.

8. Reservation of Claims. Notwithstanding any term of this Agreement, specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including Respondent) are the following:

- a. Any criminal, civil, or administrative claims arising under Title 26 U.S. Code (Internal Revenue Code);
- b. Any criminal liability;
- c. Except as explicitly stated in this Agreement, any other administrative liability, including mandatory exclusion from Federal health care programs; and
- d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct.

9. Binding on Successors. This Agreement is binding on Respondent and its successors, transferees, and assigns.

10. Costs. Each Party to this Agreement shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

11. No Additional Releases. This Agreement is intended for the benefit of the Parties only, and by this instrument the Parties do not release any claims against any other person or entity except as provided in paragraph 12.

12. Claims Against Beneficiaries. Respondent waives and shall not seek payment, including co-pay and deductible amounts, for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payers based upon the claims defined as Covered Conduct.

13. Effect of Agreement. This Agreement constitutes the complete agreement between the Parties. All material representations, understandings, and promises of the

Parties are contained in this Agreement. Any modifications to this Agreement shall be set forth in writing and signed by all Parties. Respondent represents that this Agreement is entered into with advice of counsel and knowledge of the events described herein. Respondent further represents that this Agreement is voluntarily entered into in order to avoid further administrative proceedings and litigation, without any degree of duress or compulsion.

14. Disclosure. Respondent consents to the OIG's disclosure of this Agreement, and information about this Agreement, to the public.

15. Effective Date. The Effective Date of this Agreement shall be the date of signing by the last signatory.

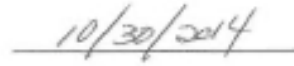
16. Execution in Counterparts. This Agreement may be executed in counterparts, each of which constitutes an original, and all of which shall constitute one and the same agreement.

17. Authorizations. The individuals signing this Agreement on behalf of the Respondent represent and warrant that they are authorized by Respondent to execute this Agreement. The individuals signing this Agreement on behalf of the OIG represent that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement.

RESPONDENT



Donna L. Rooney, JD, BSN, CHC, CPC
Vice President of Corporate Compliance
Mid-Atlantic of Delmar, LLC



Date

FOR THE OFFICE OF INSPECTOR GENERAL OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES



ROBERT K. DECONTI
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services



DATE



ADRIENNE SHELPER
Program Analyst
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services



DATE

Wire Transfer Instructions for CMS

Subtype/Type Code:	10 00
Amount:	\$92,344.60
Sending Bank Routing Number:	<i>Insert information</i>
ABA Number of Receiving Institution:	[REDACTED]
Receiver Name:	Treasury NYC
Receiving Institution Name:	[REDACTED]
Receiving Institution Address:	[REDACTED]
Beneficiary Account Number:	[REDACTED]
Beneficiary Name:	Centers for Medicare & Medicaid Services (CMS)
Beneficiary Physical Address:	7500 Security Blvd., Baltimore, MD 21244
CMS Tax ID Number:	[REDACTED]
Federal Reserve Assistance Number:	(202) 874-6894
Re:	Mid-Atlantic of Delmar OIG CMP Settlement Payment for the Employment of an Excluded Individual

Please email confirmation that the wire transfer has been made to Adrienne Shelfer at adrienne.shelfer@oig.hhs.gov



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF
LONG TERM CARE RESIDENTS PROTECTION

September 19, 2013

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

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

Dear Mr. Ayanleye:

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Robert H. Smith".

Robert H. Smith
Licensing and Certification Administrator

RHS/mam

Enclosures

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

EXHIBIT K

PURCHASE AND SALE AGREEMENT

This PURCHASE AND SALE AGREEMENT (this "Agreement") is made this 19th day of September, 2014 by and between Johns Hopkins Bayview Medical Center, Inc., a Maryland non-profit corporation (the "Seller"), and Mid-Atlantic Health Care Acquisitions, LLC, a Maryland limited liability company (the "Purchaser"), as follows:

RECITALS:

WHEREAS, Seller has certain rights, title and interest in and to eighty (80) licensed long-term care facility beds known in Maryland as comprehensive care facility ("CCF") beds (the "Bed Rights"), formerly operated as part of Johns Hopkins Bayview Care Center located at 5505 Hopkins Bayview Circle, Baltimore, Maryland 21224 (the "Prior Facility"); and

WHEREAS, Seller has received authorization from the Maryland Health Care Commission ("MHCC") with an effective date of November 15, 2013 to temporarily delicense the Facility and for the Bed Rights to be retained in the MHCC's nursing home bed inventory for a period of one (1) year from the effective date of the authorization (the "Delicensure Authorization"); and

WHEREAS, Seller desires to sell and Purchaser desires to purchase the Bed Rights so the Purchaser can operate those beds in Baltimore City, Maryland.

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

ARTICLE I

DEFINITIONS

1.1. **Definitions.** The following terms not otherwise defined in the body of this Agreement shall have the meaning set forth below:

(a) **CCF**: A duly licensed comprehensive care facility or nursing home as defined by applicable OHCCQ regulations.

(b) **MHCC**: The Maryland Health Care Commission.

(c) **OHCCQ**: The Office of Health Care Quality of the Maryland Department of Health and Mental Hygiene.

(d) **Closing Date**: The date mutually agreed upon by the parties to occur within fifteen (15) days after Purchaser's receipt of a final, non-appealable MHCC decision as expressed in a written Certificate of Need ("CON") approving Purchaser's Application for CON and authorizing Purchaser to purchase the Bed Rights and their

transfer for use in a CCF operated by Purchaser in Baltimore City, Maryland. References in this Agreement to matters to be effective on or before closing shall refer to the completion of this transaction on the Closing Date. A CON shall be considered non-appealable upon its receipt if there are no other parties with standing to file an appeal or, if there are such parties with standing to file an appeal, upon the expiration of thirty (30) days after the effective date of the CON if no appeal has been filed as of such date.

ARTICLE II

PURCHASE AND SALE

2.1. **Purchase and Sale.** Subject to the terms and conditions set forth in this Agreement, Seller agrees to sell to Purchaser, and Purchaser agrees to purchase from the Seller, all of the Seller's rights, title or interest in and to the Bed Rights, free and clear of any and all liens, claims, charges, actions, security interests, or other encumbrances of any kind, provided that Purchaser agrees to purchase the Bed Rights subject to any customary and reasonable conditions imposed by the MHCC as part of its approval of Purchaser's CON application, which conditions are approved by Purchaser in its reasonable discretion.

2.2. **Conveyance.**

(a) Seller will sell, convey, transfer, and deliver to Purchaser the Bed Rights in accordance with the terms of this Agreement upon the Closing Date.

(b) To accomplish the transfer of the Bed Rights, and provided that the Purchase Price (defined below) has been paid in full and all of the other conditions precedent to closing have been satisfied fully, Seller will execute and deliver to Purchaser on the Closing Date those documents set forth in Section 6.2.

2.3. **Purchase Price.** In consideration of the transfer of the Bed Rights, Purchaser shall pay to the Seller the sum of Five Hundred and Fifty Thousand Dollars (\$550,000.00) (the "Purchase Price"). The Purchase Price shall be payable by Purchaser to Seller in one lump sum payment of immediately available funds on the Closing Date by wire transfer to an account designated by Seller, provided that Purchaser shall receive credit against the Purchase Price paid at closing for payment of the deposits referenced in Section 2.4.

2.4. **Deposits.** Within five (5) business days of the execution of this Agreement, Purchaser shall deposit \$25,000.00 (the "Initial Deposit") in escrow (the "Escrow Account") with Bank of America, National Association, as escrow agent, pursuant to an escrow agreement executed by the parties substantially in the form attached hereto as Exhibit B. The Initial Deposit shall be refundable to Purchaser within three (3) business days if either party notifies the other in writing within three (3) business days following the expiration of the Due Diligence Period (defined hereinafter in Section 2.7 below) that it is dissatisfied with results of its due diligence and therefore is terminating the Agreement. If neither party issues a termination notice within three (3) business days following the

expiration of the Due Diligence Period, then (a) the Initial Deposit shall become non-refundable (except as set forth below) and the parties shall direct the escrow agent to release the Initial Deposit to Seller immediately, and (b) Purchaser shall make an additional refundable deposit of \$25,000.00 (the "Second Deposit") into the Escrow Account. Both the Initial and Second Deposits shall be applied to the Purchase Price on the Closing Date. In the event of a termination of this Agreement for any reason pursuant to Section 7.1 below, the Second Deposit shall be immediately returned to Purchaser within three (3) business days of the effective date of termination, but the Initial Deposit shall remain non-refundable except in the case of a termination of this Agreement pursuant to 7.1(a), in which case the Initial Deposit shall be refundable to Purchaser. Purchaser and Seller shall each be responsible for half of the costs and expenses of the escrow agent under the escrow agreement, and each shall timely pay the escrow agent its portion of such costs and expenses.

2.5. No Assumption of Obligations. Purchaser has not agreed to pay, shall not be required to assume, and shall have no liability or obligation with respect to, any liability or obligation, direct or indirect, absolute or contingent, of any type, nature or kind of Seller, any affiliate of Seller, or any other person, including, without limiting the foregoing, any liability or obligation with respect to (a) Seller's employees, (b) any outstanding financial obligation of Seller, (c) taxes owed by Seller (d) Seller's costs of delicensing of the Bed Rights for Seller's use, (e) Seller prior billing and reimbursement practices or (f) the care of any patients treated or seen by or on behalf of Seller.

2.6. Broker Fees. Seller and Purchaser represent to each other that neither has engaged the services of any broker, agent, finder or commission sales agent in connection with the transactions described in this Agreement, except that Seller has engaged Healthcare Transactions Group, Inc. ("HTG"). Seller shall be solely responsible to pay, in accordance with the terms of a separate agreement between Seller and HTG, the fee due and payable by Seller to HTG thereunder upon consummation of the transactions contemplated hereby. Each party agrees to defend, indemnify and hold the other harmless from and against any and all claims, actions and demands for any fees or commissions due, or claimed to be due, by a broker, agent, finder or commission sales agent engaged by such party.

2.7 Due Diligence. For a period of thirty (30) days from the date of execution of this Agreement (the "Due Diligence Period"), Purchaser shall have the right to conduct due diligence and obtain information concerning the regulatory status of the Bed Rights and its ability to obtain all regulatory approvals required for the consummation of the transaction hereunder. During the Due Diligence Period, Seller shall have the right to conduct due diligence and obtain information concerning the ability of Purchaser to consummate the transaction hereunder, including, without limitation, due diligence regarding Purchaser's financial condition and regulatory status. If a party determines for any reason that the results of its due diligence inspections are not satisfactory in its sole discretion, such party shall have the right to terminate this Agreement without cause or penalty within three (3) business days following the expiration of the Due Diligence Period upon written notice to the other party of the exercise of said option. In such case, this Agreement shall terminate immediately and the Initial Deposit shall be returned to

Purchaser in accordance with the terms of Section 2.4 above. Notwithstanding anything to the contrary, the Due Diligence Period shall not delay Purchaser's submission of the LOI and efforts to submit and obtain approval for the Application under Section 4.2(a).

ARTICLE III

REPRESENTATIONS AND WARRANTIES

3.1. **Representations and Warranties of Seller.** Seller represents and warrants as follows, each of which constitutes a material inducement to Purchaser's execution of this Agreement and the purchase of the Bed Rights:

(a) **Organization and Standing; Power.** Seller is a non-profit corporation duly organized, validly existing, and in good standing under the laws of the State of Maryland. Except as otherwise set forth herein, Seller has all requisite power and authority to own and operate its properties and enter into, execute, and, subject to obtaining all necessary approvals, carry out this Agreement and the transactions herein contemplated. Seller holds all applicable rights, title and interests in and to the Bed Rights.

(b) **Binding Obligation.** This Agreement is a valid and binding obligation of Seller, enforceable against Seller in accordance with its terms, subject to applicable bankruptcy, insolvency, reorganization and moratorium laws, and other laws of general application affecting enforcement of creditors' rights generally.

(c) **Authority.** The execution, delivery, and performance of this Agreement by Seller and the transactions herein contemplated will not: (i) conflict with, result in any breach or violation of, or constitute a default (or give rise to any right of termination, cancellations or acceleration) under the Articles of Incorporation or Bylaws of Seller, as amended as of the date hereof, or any note, bond, mortgage, indenture, lease, permit, agreement, or other instrument or other obligation to which Seller is a party or by which Seller is bound; or (ii) violate any law, order, license, permit, rule or regulation applicable to Seller or the Bed Rights. No consent or approval by any private third party or, to the best of Seller's knowledge, any governmental authority, except the MHCC, is required in connection with the execution, delivery, and performance of this Agreement by the Seller or the consummation of the transaction contemplated by this Agreement.

(d) **Compliance.** With respect to this Section 3.1(d), Seller states the following to the best of its knowledge without any further diligence on its part, but subject to Purchaser's due diligence under Section 2.7 above:

(i) Except as otherwise stated herein, Seller is not in violation of any applicable federal, state or municipal laws, ordinances, notices, orders, rules, regulations, decrees, awards, writs, injunctions, judgments, or requirements pertaining to the Bed Rights such that there is a material impairment of Seller's ability to consummate the transaction contemplated by this Agreement; and

(ii) Seller is not subject to or bound by any order of any court, regulatory commission, board or administrative body entered in any proceeding to which it is a party or of which it has knowledge with respect to the Bed Rights or the operation of the Prior Facility which would materially impair Seller's ability to consummate the transaction contemplated by this Agreement.

(e) Licenses and Approvals. Seller holds in good standing all licenses, permits, approvals, and other authorizations necessary to own the Bed Rights (the "Licenses"), subject to the Delicensure Authorization. Seller is not a party to and has no knowledge of any proceedings, pending or to the Seller's knowledge threatened, to revoke or limit the scope of any Licenses, and is not in violation of any of the Licenses. Seller has obtained approval from the MHCC, and given notice to the OHCQ, to temporarily delicense the Prior Facility and the Bed Rights, and pursuant thereto has ceased operation of the Bed Rights. None of the Bed Rights are currently in operation, and there are no patients currently occupying the beds that are the subject to the Bed Rights. Seller shall also timely file all required Seller notices, if any, with the MHCC and or the OHCQ to advise them of the transaction contemplated by this Agreement and to preserve the Licenses in good standing (subject to Delicensure Authorization) following execution of this Agreement. As of the Closing Date, Seller shall have taken all necessary steps, including the timely filing of further Seller notices to the MHCC and the OHCQ, to transfer to Purchaser the Bed Rights and its right to operate the Bed Rights, and shall have reasonably cooperated with Purchaser to enable Purchaser to purchase the Bed Rights, it being agreed that, after the Closing, Purchaser is solely responsible for complying with the terms of the Certificate of Need approval and developing and operating its CCF.

(f) Interest in the Bed Rights. Except as otherwise set forth herein, Seller holds a transferable interest in the Bed Rights, and on the Closing Date, Seller shall transfer the Bed Rights free and clear of any liens, restrictions or encumbrances other than the requirement that Purchaser obtain the requisite approvals from the MHCC before being able to operate the Bed Rights.

(g) No Impediments. To the best of Seller's knowledge, there are no matters that could delay, impede, or otherwise prevent Seller or Purchaser from consummating the transactions contemplated by this Agreement.

(h) General. All representations and warranties by Seller herein are true, complete and accurate in all material respects as of the date of this Agreement and will be true, complete and accurate in all material respects as of the Closing and do not contain and will not contain an untrue statement of any material fact, or omit to state a material fact necessary in order to make all of such representations and warranties not materially misleading as of this date and as of the Closing Date.

3.2. Representations and Warranties of Purchaser. Purchaser represents and warrants as follows, each of which constitutes a material inducement to Seller's execution of this Agreement and the sale of the Bed Rights:

(a) Organization and Standing; Power. Purchaser is a Maryland limited liability company duly organized, validly existing, and in good standing under the laws of the State of Maryland. Purchaser has all requisite power and authority to own and operate its properties and enter into, execute, and carry out this Agreement and the transactions being contemplated.

(b) No Impediments. To the best of Purchaser's knowledge, there are no matters that could delay, impede, or otherwise prevent Seller or Purchaser from consummating the transactions contemplated by this Agreement.

(c) Binding Obligation. This Agreement is a valid and binding obligation of Purchaser, enforceable against Purchaser in accordance with its terms, subject to applicable bankruptcy, insolvency, reorganization and moratorium laws, and other laws of general application affecting enforcement of creditors' rights generally.

(d) General. All representations and warranties by Purchaser herein are true, complete and accurate in all material respects as of the date of this Agreement and will be true, complete and accurate in all material respects as of the Closing and do not contain and will not contain an untrue statement of any material fact, or omit to state a material fact necessary in order to make all of such representations and warranties not materially misleading as of this date and as of the Closing Date.

3.3 Knowledge. For purposes of this Agreement, the term "knowledge" as applicable to a party shall mean that no trustee or officer of the party has received any actual knowledge as to the subject matter of the representation in question.

ARTICLE IV

COVENANTS

4.1. Covenants of Seller. Seller covenants to Purchaser that, except as otherwise consented to in writing by Purchaser after the date of this Agreement:

(a) Regulatory Approvals. Seller agrees to participate in meetings with MHCC and the OHCQ upon reasonable request of Seller and to provide Seller with all information and documentation concerning the Bed Rights as Purchaser may reasonably request to support its CON application, all at no cost or expense to the Seller. Prior to November 15, 2014, Seller agrees to submit to the MHCC a binding contract to transfer ownership of the Bed Rights to Purchaser pursuant to MHCC Regulations, along with all associated documentation as required by MHCC (the "Bed Transfer Contract").

(b) No Inconsistent Action. Seller will not take any action that is inconsistent with or impairs the consummation of the transaction contemplated by this Agreement, including, without limitation, attempting to re-license, activate or otherwise operationalize the Bed Rights for its own use or the use of any third party other than Purchaser. During the term of this Agreement, Seller will (i) deal exclusively with Purchaser with respect to the purchase and sale of the Bed Rights, (ii) not, directly or

indirectly, solicit, initiate or encourage any inquiry proposal, offer or contract from any other person or entity for the purchase and sale of the Bed Rights, and (iii) not participate in any discussions or negotiations with any other person or entity with respect to the purchase and sale of the Bed Rights. Seller will notify Purchaser promptly of any matters that could delay, impede or otherwise prevent Seller from consummating this transaction.

(c) Disclosure. Seller will inform Purchaser promptly of anything that would make Seller's representations, warranties, and disclosures made herein materially untrue or materially misleading or which constitutes a material breach of any covenant contained herein.

4.2. Covenants of Purchaser.

(a) Regulatory Approval for Transfer of the Bed Rights. Purchaser, at its own expense, shall use commercially reasonable efforts to obtain the MHCC's approval of an Application for Certificate of Need authorizing the transfer of Seller's rights to the Bed Rights to Purchaser for use in its CCF in Baltimore City, Maryland as soon as reasonably practicable. Following the execution of this Agreement, Purchaser shall file a Letter of Intent to file a Certificate of Need Application with the MHCC on or before December 15, 2014 (the "LOI") and shall file an Application for Certificate of Need with the MHCC on or before April 10, 2015 (the "Application"), all in accordance with the review schedule published by the MHCC, unless the MHCC publishes a revised review schedule, in which case Purchaser shall use commercially reasonable efforts to comply with that schedule. Purchaser shall comply fully with all requests for information, plans, or other materials sought by the MHCC in a timely fashion, and shall use commercially reasonable efforts to secure the CON contemplated by this Agreement as soon as reasonably practicable, including without limitation, obtaining a site on which the Bed Rights will be located.

(b) No Inconsistent Action. Purchaser will not take any action that is inconsistent with, materially delays or impairs the consummation of the transaction contemplated by this Agreement. Purchaser will notify Seller promptly of any matters that could delay, impede or otherwise prevent Purchaser from consummating this transaction.

(c) Disclosure. Purchaser will inform Seller promptly of anything that would make Purchaser's representations, warranties, and disclosures made herein materially untrue or materially misleading or which constitutes a material breach of any covenant contained herein.

ARTICLE V

CONDITIONS

5.1 **Conditions to Purchaser's Obligations.** Unless waived by Purchaser in writing at its sole discretion, all obligations of Seller under this Agreement are subject to the fulfillment of each of the following conditions at or prior to the closing:

(a) **Representations and Warranties.** The representations and warranties of Seller contained in this Agreement shall continue to be true and correct as of the Closing Date in all material respects.

(b) **Covenants.** Seller shall have performed all obligations and complied with all covenants required by this Agreement to be performed or complied with by it on or prior to the Closing Date, as applicable.

(c) **MHCC Approval.** A final, non-appealable MHCC decision approving an Application for Certificate of Need authorizing Purchaser to purchase and relocate the Bed Rights to and for use in its CCF operated by Purchaser in Baltimore City, Maryland shall have been received by Purchaser, which final decision may be subject to ordinary limited conditions typically imposed by the MHCC under similar circumstances. In the event that, notwithstanding Purchaser's best efforts, such MHCC approval is not obtained and the MHCC denies the Application for Certificate of Need, subject to Sections 7.2 and 7.3, this Agreement shall be null and void, provided, however, that if the Purchaser in its sole discretion determines to undertake a judicial appeal of the MHCC's denial, this Agreement shall continue in full force and effect during the pendency of any appeals.

(d) **Execution of Closing Documents.** Seller at closing shall have executed, acknowledged, and delivered to Purchaser each of the documents described in Section 6.2 hereof.

5.2. **Conditions to Seller's Obligations.** Unless waived by Seller in writing at its sole discretion, all obligations of Purchaser under this Agreement are subject to the fulfillment of each of the following conditions at or prior to the Closing Date:

(a) **Representations and Warranties.** The representations and warranties of Purchaser contained in this Agreement shall continue to be true and correct as of the Closing Date in all material respects.

(b) **Covenants.** Purchaser shall have performed all obligations and complied with all covenants required by this Agreement to be performed or complied with by it on or prior to the Closing Date, as applicable.

(c) **MHCC Approval.** A final, non-appealable MHCC decision approving an Application for Certificate of Need authorizing Purchaser to purchase and relocate the Bed Rights to and for use in its CCF operated by Purchaser in Baltimore City, Maryland shall have been received by Purchaser, which final decision may be subject to ordinary

limited conditions typically imposed by the MHCC under similar circumstances. In the event that, notwithstanding Purchaser's best efforts, such MHCC approval is not obtained and the MHCC denies the Application for Certificate of Need, subject to Sections 7.2 and 7.3, this Agreement shall be null and void, provided, however, that if the Purchaser in its sole discretion determines to undertake a judicial appeal of the MHCC's denial, this Agreement shall continue in full force and effect during the pendency of any appeals.

(d) Payment of the Purchase Price. Purchaser shall have paid the Purchase Price on the Closing Date in accordance with Section 2.3 above.

(e) Execution of Closing Documents. Purchaser at closing shall have executed, acknowledged, and delivered to Seller each of the documents described in Section 6.2 hereof.

ARTICLE VI

CLOSING

6.1 Closing Date. In accordance with the terms of this Agreement, the closing shall take place on the Closing Date in the offices of Seller's attorney, or at such other place mutually agreed upon by the parties.

6.2 Closing Obligations. At Closing, the parties shall execute and deliver the following documents:

(a) The Seller shall execute and deliver an Assignment of Intangibles conveying all of Seller's right, title, and interest in and to the Bed Rights in the form of the Assignment attached as Exhibit A; and

(b) The parties shall execute and deliver such other documents and instruments as either party may reasonably require to consummate the transactions contemplated by this Agreement.

ARTICLE VII

DEFAULT; TERMINATION

7.1 Right to Terminate.

(a) Purchaser shall have the right to terminate this Agreement by written notice sent to Seller, at any time prior to the Closing Date if Seller is in material breach of any of the terms hereof, which breach or violation materially impairs Purchaser's ability to consummate this transaction; provided, however, Seller is provided at least thirty (30) days advance written notice and is afforded an opportunity to cure the breach.

(b) Seller shall have the right to terminate this Agreement by written notice sent to Purchaser, at any time prior to the Closing Date if Purchaser is in material

breach of any of the terms hereof, which breach or violation materially impairs Seller's ability to consummate this transaction; provided, however, Purchaser is provided at least thirty (30) days advance written notice and is afforded an opportunity to cure the breach.

(c) Either party may terminate this Agreement by providing written notice to the other party if the Closing Date has not occurred for any reason within twenty-four (24) months of the date of this Agreement, provided that Purchaser may request, and Seller may provide written approval in writing for, an extension of the foregoing twenty-four (24) month period, which consent Seller shall not unreasonably withhold.

(d) A party may terminate this Agreement in accordance with the terms of Section 2.7 above.

(e) A party may terminate this Agreement prior to the Closing Date by providing at least sixty (60) days' prior written notice to the other party in the event that the terminating party reasonably concludes that the Closing Date will not occur within the twenty-four (24) month period described in Section 7.1(c) above (subject to any extensions granted by Seller) or the transaction contemplated by this Agreement is otherwise incapable of being consummated, provided that a party may not terminate under this paragraph if (1) the terminating party is in material breach at the time of termination and (2) if the delay in closing is caused by the breach.

7.2 Procedure Upon Termination. In the event of termination by a party pursuant to Section 7.1, written notice thereof shall be given as provided herein and the transaction contemplated by this Agreement shall be terminated without further action or notice by either party. If the transaction contemplated by this Agreement is terminated as provided herein:

(a) Seller and Purchaser shall return all documents, work papers, and other material of any other party relating to the transaction contemplated hereby (or copies thereof), whether obtained before or after the execution hereof, to the party furnishing the same.

(b) All confidential information received by Seller or Purchaser with respect to the business of any other party or its affiliates shall be treated in accordance with Section 9.2 hereof.

7.3 LIMITATION OF LIABILITY. TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR ANY INDIRECT, SPECIAL, PUNITIVE, EXEMPLARY OR CONSEQUENTIAL DAMAGES UNDER THIS AGREEMENT OR ARISING FROM ANY ACTIVITIES CONDUCTED PURSUANT TO THIS AGREEMENT, EVEN IF A PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. SELLER'S TOTAL LIABILITY UNDER THIS AGREEMENT AND PURCHASER'S RIGHT TO RECOVER ANY DAMAGES (INCLUDING REASONABLE ATTORNEY'S FEES OR ANY OTHER COSTS OR EXPENSES), SHALL BE ABSOLUTELY LIMITED TO THE AMOUNT OF THE

PURCHASE PRICE PAID BY PURCHASER TO SELLER HEREUNDER. THE LIMITATIONS OF LIABILITY IN THIS PARAGRAPH SHALL NOT APPLY TO A PARTY'S BREACH OF SECTION 9.2.

7.4. **Time is of the Essence**. The parties acknowledge and agree that time is of the essence with respect to the each parties' obligations under this Agreement.

7.5. **Remedies**. The parties agree that irreparable damage may occur in the event of a breach by a party hereunder. It is accordingly agreed that a non-breaching party may seek appropriate equitable relief in the event of party's breach, without prejudice to any other rights and remedies that the non-breaching party may have at law or in equity.

ARTICLE VIII

SURVIVAL

8.1. **Survival**. The representations, warranties, and agreements made by the parties in this Agreement and in any certificates and documents delivered in connection herewith, shall survive the Closing Date for a period of six (6) months regardless of any investigation made by the party making claim hereunder, and thereafter automatically shall terminate, provided that, if a party makes a claim with respect to any representation, warranty or agreement herein within such six (6) month period, then such representation, warranty or agreement shall survive only as it concerns the pending claim until the final determination of the matter.

ARTICLE IX

MISCELLANEOUS

9.1. **Third Parties**. Nothing herein expressed or implied is intended or shall be construed to confer upon or give to any person other than the parties hereto and their successors and assigns any rights or remedies under or by reason of this Agreement.

9.2. **Confidentiality**. Prior to the Closing Date, Purchaser and Seller shall hold, and shall cause their employees, representatives, agents, and affiliated persons to hold, in strict confidence and not use in any way except in connection with the transactions contemplated hereby, any confidential or proprietary information obtained from the other party in connection with the transactions contemplated by this Agreement, except such information may be disclosed: (i) to regulatory authorities or governmental agencies and to any other person to the extent necessary to obtain the consents or approvals contemplated by this Agreement; (ii) if required by court order or decree or applicable law; (iii) if it is publicly available through no act or failure to act of the disclosing party; (iv) during the course of or in connection with any litigation, governmental investigation, arbitration, or other proceedings based upon or in connection with the subject matter of this Agreement; (v) upon the prior written consent of the other party; or (vi) if it is otherwise expressly provided for herein. In the event that a disclosure is required under Section 9.2(ii) or 9.2(iv), the disclosing party shall provide reasonable prior written notice of the disclosure and will reasonably cooperate with the other party as requested

to protect the information to be disclosed.

9.3 **Notices.**

(a) All notices, requests, demands, and other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally, by overnight courier, or mailed first-class, postage prepaid, registered or certified mail, as follows:

If to Seller:

Johns Hopkins Bayview Medical Center, Inc.
5300 Alpha Commons Drive
Alpha Commons Building, Executive Offices
Baltimore, MD 21224-2780

With a copy to:

G. Daniel Shealer, Esq.
Vice President & General Counsel
The Johns Hopkins Health System Corporation
600 N. Wolfe Street
Baltimore, MD 21287-1900

If to the Purchaser:

Mid-Atlantic Health Care Acquisitions, LLC
1922 Greenspring Drive, Suite #3
Timonium, Maryland 21093
Attn: Chief Executive Officer

With a copy to:

Miles & Stockbridge, P.C.
100 Light Street
Baltimore, Maryland 21202
Attn: Joseph P. Ward, Esq.

(b) The parties may change the address to which such communications are to be directed by giving written notice to the other in the manner provided in this Section.

(c) Any such notice, request, consent, or other communication shall be deemed received at such time as it is personally delivered or on the third business day after it is so mailed, as the case may be.

9.4. **No Waiver; Cumulative Remedies.** No failure by a party to exercise and no delay in exercising any right, power, privilege, or discretion under this Agreement shall operate as a waiver thereof; nor shall any single or partial exercise of any right, power,

privilege, or discretion hereunder preclude any other exercise thereof; nor shall any waiver thereof be effective unless in writing and signed by the party waiving the same.

9.5. **Applicable Law.** This Agreement is made, executed and delivered in the State of Maryland, and Maryland law shall govern its interpretation, performance, and enforcement, exclusive of conflict of law rules.

9.6 **Forum.** The Parties consent to submit to the exclusive jurisdiction of the courts of the State of Maryland located in Howard County for any proceeding arising in connection with this Agreement, and each Party agrees not to commence any such proceeding except in such courts. The Parties waive any objection to the laying of venue of any such proceeding in the courts of the State of Maryland located in Howard County.

9.7. **Entire Agreement.** This Agreement, including the recitals set forth above which are intended to be an integral part hereof, sets forth the entire agreement and understanding of the parties with respect to the transactions contemplated hereby and supersedes all prior agreements, arrangements, and understandings relating to the subject matter hereof.

9.8. **Severability.** In case one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

9.9. **General.** The Section headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement. All references made in the neuter, masculine, or feminine gender shall be deemed to have been made in all such genders; and in the singular or plural number shall be deemed to have been made respectively, in the plural or singular number as well.

9.10 **Assignment.** This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns. Purchaser may not assign or delegate its rights or obligations hereunder without the prior written consent of Seller, provided that Purchaser shall be permitted to assign all of its rights and obligations under this Agreement without the consent of Seller to any entity (whether currently existing or hereafter created) that is owned solely by all of the same members of Purchaser . Any such assignment or delegation, however, shall not relieve Purchaser of any obligations under the terms of this Agreement, and Purchaser agrees to unconditionally guarantee the full and complete performance hereunder by its assignee.

9.11. **Expenses.** Purchaser and Seller shall each pay all of its own expenses relating to the transaction contemplated by this Agreement, including but not limited to the fees and disbursements of their respective counsel, accountants, consultants, and financial

advisors, whether or not the transactions contemplated hereunder are consummated.

9.12. **Counterparts**. This Agreement may be executed in any number of counterparts, each of which shall be an original with the same effect as if the signatures thereto and hereto were upon the same instrument. Any signature duly affixed to this Agreement and delivered by facsimile transmission or in PDF format shall be deemed to have the same legal effect as the actual signature of the person signing this Agreement. Any Party receiving delivery of a facsimile or PDF copy of the signed Agreement may rely on such as having actually been signed.

9.13 **Public Announcements**. Unless required to do so by applicable law or regulation, Purchaser and Seller each agree that it shall not release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding this Agreement or the transactions contemplated hereby without the prior written consent of the other Party except for purposes of obtaining the Regulatory Approvals.

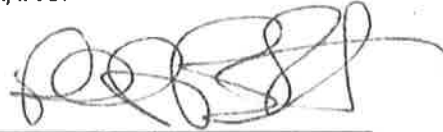
[This space is intentionally left blank. Signature page to follow.]

IN WITNESS WHEREOF, the parties hereto have executed and sealed this Purchase and Sale Agreement as of the day and year first written above.

SELLER:

JOHNS HOPKINS BAYVIEW MEDICAL
CENTER, INC.

By:



Richard G. Bennett, M.D.
President

PURCHASER:

MID-ATLANTIC HEALTH CARE
ACQUISITIONS, LLC

By:

Name:
Title:

IN WITNESS WHEREOF, the parties hereto have executed and sealed this Purchase and Sale Agreement as of the day and year first written above.

SELLER:

JOHNS HOPKINS BAYVIEW MEDICAL
CENTER, INC.

By: _____

Richard G. Bennett, M.D.
President

PURCHASER:

MID-ATLANTIC HEALTH CARE
ACQUISITIONS, LLC

By: _____

Name: SCOTT RIFKIN
Title: MANAGING MEMBER

EXHIBIT A

ASSIGNMENT OF INTANGIBLES

KNOW ALL MEN BY THESE PRESENTS, that the undersigned, Johns Hopkins Bayview Medical Center, Inc., a Maryland non-profit corporation ("Seller"), for good and valuable consideration to it paid by [Mid-Atlantic Health Care Acquisitions], LLC, a Maryland limited liability company ("Purchaser"), the receipt of which is hereby acknowledged, does hereby grant, bargain, sell and transfer to Purchaser, its successors and assigns, all its right, title, and interest in and to eighty (80) Comprehensive Care Facility Beds identified as the Bed Rights in the Purchase and Sale Agreement (the "Agreement") dated September 19, 2014 by and between Seller and Purchaser.

AND TO HAVE AND TO HOLD all and singular the aforesaid property to Purchaser, its successors and assigns forever.

Seller warrants and represents that it has and is conveying to Purchaser good title to the aforesaid Bed Rights, free and clear of all mortgages, liens, claims and encumbrances, and Seller covenants and agrees to warrant and defend title to said property unto Purchaser, its successors and assigns.

IN WITNESS WHEREOF, Seller has caused this instrument to be executed this ____ day of _____, 2014.

SELLER:

JOHNS HOPKINS BAYVIEW MEDICAL
CENTER, INC.

By: _____
Richard G. Bennett, M.D.
President

EXHIBIT B

ESCROW AGREEMENT

ESCROW AGREEMENT

THIS ESCROW AGREEMENT (the "*Agreement*") is made and entered into as of September __, 2014, by and among Johns Hopkins Bayview Medical Center, Inc., a not-for-profit corporation organized under the laws of the State of Maryland ("JHBMC"), Mid-Atlantic Health Care Acquisitions, LLC, a limited liability company organized under the laws of the State of Maryland ("Mid-Atlantic"), and Bank of America, National Association, a national banking association duly organized and existing under the laws of the United States of America, having an office in Chicago, Illinois (the "*Escrow Agent*"). JHBMC and Mid-Atlantic are individually referenced herein as a "Party" and collectively as the "Parties".

WHEREAS, JHBMC and Mid-Atlantic have entered into that certain Purchase and Sale Agreement dated as of September 19, 2014 (the "Purchase Agreement") under which Mid-Atlantic seeks to purchase, and JHBMC seeks to sell to Mid-Atlantic, certain rights, title and interests of JHBMC in and to eighty (80) licensed long-term care facility beds known in Maryland as comprehensive care facility ("CCF") beds (the "Bed Rights"), formerly operated as part of Johns Hopkins Bayview Care Center located at 5505 Hopkins Bayview Circle, Baltimore, Maryland 21224; and

WHEREAS, pursuant to Section 2.4 of the Purchase Agreement, Mid-Atlantic is required to pay two deposits which together total fifty thousand dollars (\$50,000.00) in escrow to be applied toward the purchase price for the Bed Rights.

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

ARTICLE I ESTABLISHMENT OF ESCROW

(a) Within five (5) business days of the Parties' execution of the Purchase Agreement, Mid-Atlantic will deposit twenty-five thousand dollars (\$25,000.00) (the "*Initial Deposit*") with the Escrow Agent. It is acknowledged that additional deposits may be made following the Initial Deposit in accordance with the terms of the Purchase Agreement. The Initial Deposit as well as any additional deposits, shall hereinafter collectively be referred to as the "*Escrow Fund*."

(b) The parties hereto hereby appoint the Escrow Agent, and the Escrow Agent hereby agrees to serve, as the escrow agent and depositary subject to the terms and conditions set forth herein. The Escrow Agent shall receive the Initial Deposit and any additional deposits and agrees to hold the Escrow Fund in a separate and distinct account (the "*Escrow Account*") which is hereby established and which will be held and disbursed by the Escrow Agent only in accordance with the express terms and conditions of this Agreement. The Escrow Agent may accept an item for deposit into the Escrow Account from either Party. Escrow Agent is not required to question the authority of the person

making the deposit on behalf of a Party.

ARTICLE II

INVESTMENT OF ESCROW FUND

The Escrow Fund shall remain uninvested. The parties hereto hereby acknowledge and agree that they will not have any claim or cause of action against the Escrow Agent for its failure to invest the Escrow Fund in an interest bearing or otherwise accreting account, and each Party shall indemnify and hold the Escrow Agent harmless from any such claim (and any expenses incurred defending such claim) asserted, as applicable, by any of its respective shareholders, creditors, trustee(s) in bankruptcy or other persons not a party to this Agreement.

ARTICLE III

DISBURSEMENTS FROM THE ESCROW ACCOUNT

The Escrow Agent shall only disburse amounts held in the Escrow Account upon receipt of a written notice ("*Disbursement Request*") from JHBMC and Mid-Atlantic two (2) Business Days prior to the requested disbursement date specifying (i) the amount to be disbursed, (ii) the date of disbursement, (iii) the recipient of the disbursement, and (iv) the manner of disbursement and delivery instructions. A form of Disbursement Request is attached hereto as Annex I. For the avoidance of doubt, if any Disbursement Request authorizes the disbursement of all of the then-remaining Escrow Funds, such Disbursement Request shall constitute a Termination Notice (as defined below) and shall be treated as such in accordance with the provisions of Article VII. Further, the Escrow Agent is authorized to obtain confirmation of such Disbursement Request by telephone call-back to the person or persons designated for verifying such requests on Exhibit B (such person verifying the request shall be different than the person initiating the request).

ARTICLE IV

COMPENSATION; EXPENSES

As compensation for its services to be rendered under this Agreement, for each year or any portion thereof, the Escrow Agent shall receive a fee in the amount specified in Exhibit A to this Agreement and shall be reimbursed upon request for all expenses, disbursements and advances, including reasonable fees of outside counsel, if any, incurred or made by it in connection with the carrying out of its duties under this Agreement. Mid-Atlantic and JHBMC shall each be responsible for paying half of such fees and expenses. The Escrow Agent is hereby authorized and directed to withdraw from the Escrow Funds any fees or expenses that have been invoiced but that have remained unpaid for sixty (60) days or more. Further, and in addition to the right given to it in the preceding sentence, the Escrow Agent is hereby authorized to withhold any disbursement it would otherwise make from the Escrow Account if at the time of such disbursement any invoiced fees or expenses remain unpaid. In the event of a withdrawal by Escrow Agent from the Escrow Funds to pay fees or expenses of the Escrow Agent, JHBMC and Mid-Atlantic each agree to immediately make an additional deposit (equal to half of the amount of such unpaid fees or expenses) into the escrow account in order to

bring the balance back to its intended balance as contemplated by the Purchase Agreement. Amounts due for fees and expenses at the time this Agreement is executed shall be deemed to have been invoiced at such time and for purposes of this Article IV shall be deemed an invoice. It is understood that the foregoing provisions may affect the disbursement of funds to parties not responsible for the payment of fees and expenses.

ARTICLE V

REPRESENTATIONS AND WARRANTIES

The Parties each hereto hereby represents and warrants as of the date hereof and each date prior to the termination of this Agreement as follows:

- (a) such party is duly organized, validly existing and in good standing under the laws of the State of its organization;
- (b) such Party has all requisite corporate or other power, authority and capacity, and such other consents and approvals as are required to enter into this Agreement and to perform the obligations required of it hereunder and thereunder. The execution and delivery of this Agreement, and the consummation of the transactions contemplated herein, have been duly and validly authorized by all necessary action. This Agreement constitutes a valid and legally binding agreement of such Party enforceable in accordance with its terms, and no offset, counterclaim or defense exists to the full performance by such Party of this Agreement, except as the same may be limited by bankruptcy, insolvency, reorganization and similar laws affecting the enforcement of creditors' rights generally and by general equity principles;
- (c) such Party is in full compliance with all applicable anti-money laundering and anti-terrorist financing laws and regulations;
- (d) the Escrow Account will be used by such Party for business use only and not primarily for personal, family or household use;
- (e) such Party will not use the Escrow Account for illegal transactions, including, without limitation, those prohibited by the Unlawful Internet Gambling Enforcement Act, 31 U.S.C. Section 5361 et. seq.

ARTICLE VI

EXCUPLATION AND INDEMNIFICATION

6.1(a) The obligations and duties of the Escrow Agent are confined to those specifically set forth in this Agreement which obligations and duties shall be deemed purely ministerial in nature. No additional obligations and duties of the Escrow Agent shall be inferred or implied from the terms of any other documents or agreements, notwithstanding references herein to other documents or agreements. In the event that any of the terms and provisions of any other agreement between any of the parties hereto

conflict or are inconsistent with any of the terms and provisions of this Agreement, the terms and provisions of this Agreement shall govern and control the duties of the Escrow Agent in all respects. The Escrow Agent shall not be subject to, or be under any obligation to ascertain or construe the terms and conditions of any other instrument, or to interpret this Agreement in light of any other agreement whether or not now or hereafter deposited with or delivered to the Escrow Agent or referred to in this Agreement. The Escrow Agent shall not be obligated to inquire as to the form, execution, sufficiency, or validity of any such instrument nor to inquire as to the identity, authority, or rights of the person or persons executing or delivering same. The Escrow Agent shall have no duty to know or inquire as to the performance or nonperformance of any provision of any other agreement, instrument, or document. The parties hereto shall provide the Escrow Agent with a list of authorized representatives, initially authorized hereunder as set forth on Exhibit B; as such Exhibit B may be amended or supplemented from time to time by delivery of a revised and re-executed Exhibit B to the Escrow Agent. The Escrow Agent may, but is not required to, investigate payment instructions, make further inquiries, and, where required, block or reject services due to domestic or global economic or trade-based sanctions. Notwithstanding the foregoing sentence, the Escrow Agent is authorized to comply with and rely upon any notices, instructions or other communications believed by it to have been sent or given by a person or persons authorized by the parties. The Escrow Agent specifically allows for receiving direction by written or electronic transmission from an authorized representative with the following caveat, the Parties agree to indemnify and hold harmless the Escrow Agent against any and all claims, losses, damages, liabilities, judgments, costs and expenses (including reasonable attorneys' fees) (collectively, "Losses") incurred or sustained by the Escrow Agent as a result of or in connection with the Escrow Agent's reliance upon and compliance with instructions or directions given by written or electronic transmission, provided, however, that such Losses have not arisen from the gross negligence or willful misconduct of the Escrow Agent.

(b) In the event funds transfer instructions are given to the Escrow Agent pursuant to the terms of this Agreement (other than with respect to fund transfers to be made contemporaneously with the execution of this agreement), regardless of the method used to transmit such instructions, such instructions must be given by an individual designated on Exhibit B. Further, the Escrow Agent is authorized to obtain and rely upon confirmation of such instructions by telephone call-back to the person or persons designated for verifying such instructions on Exhibit B (such person verifying the instruction shall be different than the person initiating the instruction). The parties hereto aside from the Escrow Agent agree that the Escrow Agent may delay the initiation of any fund transfer until all security measures it deems to be necessary and appropriate have been completed and shall incur no liability for such delay.

6.2 The Escrow Account shall be maintained in accordance with applicable laws, rules and regulations and policies and procedures of general applicability to accounts established by the Escrow Agent. The Escrow Agent shall not be liable for any act that it may do or omit to do hereunder in good faith and in the exercise of its own best judgment or for any damages not directly resulting from its gross negligence or willful misconduct. Without limiting the generality of the foregoing sentence, it is hereby agreed that in no event will the Escrow Agent be liable for any lost profits or other indirect, special,

incidental or consequential damages which the parties may incur or experience by reason of having entered into or relied on this Agreement or arising out of or in connection with the Escrow Agent's duties hereunder, notwithstanding that the Escrow Agent was advised or otherwise made aware of the possibility of such damages. The Escrow Agent shall not be liable for acts of God, acts of war, breakdowns or malfunctions of machines or computers, interruptions or malfunctions of communications or power supplies, labor difficulties, actions of public authorities, or any other similar cause or catastrophe beyond the Escrow Agent's reasonable control. Any act done or omitted to be done by the Escrow Agent pursuant to the advice of its attorneys shall be conclusively presumed to have been performed or omitted in good faith by the Escrow Agent.

6.3 In the event the Escrow Agent is notified of any dispute, disagreement or legal action relating to or arising in connection with the escrow, the Escrow Fund, or the performance of the Escrow Agent's duties under this Agreement, the Escrow Agent will not be required to determine the controversy or to take any action regarding it. The Escrow Agent may hold all documents and funds and may wait for settlement of any such controversy by final appropriate legal proceedings, arbitration, or other means as, in the Escrow Agent's discretion, it may require. Furthermore, if confronted with conflicting demands such that it determines in good faith that it risks incurring expense or liability regardless of any action it may take or refrain from taking, the Escrow Agent may, at its option, file an action of interpleader requiring the parties to answer and litigate any claims and rights among themselves. The Escrow Agent is authorized, at its option, to deposit with the court in which such action is filed, all documents and funds held in escrow, except all costs, expenses, charges, and reasonable attorneys' fees incurred by the Escrow Agent due to the interpleader action and which JHBMC and Mid-Atlantic agree on a joint and several basis to pay. Upon initiating such action, the Escrow Agent shall be fully released and discharged of and from all subsequent obligations and liability otherwise imposed by the terms of this Agreement.

6.4 The Parties hereby agree, on a joint and several basis, to indemnify and hold the Escrow Agent, and its directors, officers, employees, and agents, harmless from and against all costs, damages, judgments, attorneys' fees (whether such attorneys shall be regularly retained or specifically employed), expenses, obligations and liabilities of every kind and nature which the Escrow Agent, and its directors, officers, employees, and agents, may incur, sustain, or be required to pay in connection with or arising out of this Agreement, unless the aforementioned results from the Escrow Agent's gross negligence or willful misconduct, and to pay the Escrow Agent on demand the amount of all such costs, damages, judgments, attorneys' fees, expenses, obligations, and liabilities. Without limitation, the foregoing indemnities shall extend to any breach of the representations, warranties or covenants in Section 10.3 of this Agreement. The costs and expenses of enforcing this right of indemnification also shall be paid by the Parties. The foregoing indemnities in this paragraph shall survive the resignation or substitution of the Escrow Agent and the termination of this Agreement.

ARTICLE VII

TERMINATION OF AGREEMENT

This Agreement shall terminate:

(a) On the termination date set forth in a properly executed and delivered Termination Notice (as defined below). The Parties may, at any time, terminate this Agreement by delivering to the Escrow Agent written notice (the "*Termination Notice*") signed by the Parties setting forth (i) the requested termination date and (ii) instructions for the return or delivery of the parties' then-escrowed property. The Termination Notice shall be received by the Escrow Agent not fewer than two (2) Business Days prior to the requested termination date. A form of Termination Notice is attached hereto as Exhibit C.

(b) Should the Parties terminate the Agreement pursuant to this Article VII, it is understood and agreed by each of them that the Escrow Agent shall be entitled (i) to keep any monies paid to it in respect of fees or expenses previously due and owing and (ii) to offset from the amount of Escrow Funds on deposit as of the date of the Termination Notice, any amounts due for fees and expenses that, as of such date, have been previously invoiced and remain unpaid or which are then due and payable on a *pro rata* basis. Notwithstanding any other provision hereof, this Agreement shall not terminate before all amounts in the Escrow Account shall have been distributed by the Escrow Agent in accordance with the terms of this Agreement.

ARTICLE VIII **RESIGNATION OF ESCROW AGENT**

The Escrow Agent may resign at any time upon giving at least thirty (30) days prior written notice to JHBMC and Mid-Atlantic; provided that no such resignation shall become effective until the appointment of a successor escrow agent which shall be accomplished as follows: JHBMC and Mid-Atlantic shall use their best efforts to select a successor escrow agent within thirty (30) days after receiving such notice. If JHBMC and Mid-Atlantic fail to appoint a successor escrow agent within such time, the Escrow Agent shall have the right at the joint expense of JHBMC and Mid-Atlantic to petition any court of general jurisdiction sitting in Cook County, Illinois for the appointment of a successor escrow agent. The successor escrow agent shall execute and deliver an instrument accepting such appointment and it shall, without further acts, be vested with all the estates, properties, rights, powers, and duties of the predecessor escrow agent as if originally named as escrow agent. Upon delivery of such instrument, the Escrow Agent shall be discharged from any further duties and liability under this Agreement. The Escrow Agent shall be paid any outstanding fees and expenses prior to transferring assets to a successor escrow agent.

ARTICLE IX **NOTICES**

All notices required by this Agreement shall be in writing and shall be deemed to have been received (a) immediately if sent by hand delivery (with signed return receipt), (b) the next Business Day if sent by nationally recognized overnight courier or (c) the second following Business Day if sent by registered or certified mail, in any case to the respective addresses as follows:

If to JHBMC:

Johns Hopkins Bayview Medical Center, Inc.
5300 Alpha Commons Drive
Alpha Commons Building, Executive Offices
Baltimore, MD 21224-2780
Attn: President

With a copy to:

G. Daniel Shealer, Esq.
Vice President & General Counsel
The Johns Hopkins Health System Corporation
600 N. Wolfe Street, Admin. 400
Baltimore, MD 21287-1900

If to Mid-Atlantic:

Mid-Atlantic Health Care Acquisitions, LLC
922 Greenspring Drive, Suite #3
Timonium, Maryland 21093
Attn: Chief Executive Officer

If to the Escrow Agent:

Bank of America, National Association
Global Custody and Agency Services
135 S. LaSalle Street
IL4-135-05-07
Chicago, Illinois 60603
Attention: Arlene Kaminski

ARTICLE X

TAX REPORTING

10.1 The Parties understand and agree that they are required to provide the Escrow Agent with a properly completed and signed Tax Certification (as defined below) and that the Escrow Agent may not perform its duties hereunder without having been provided with such Tax Certification. Accordingly, the Parties understand and agree that unless and until all Parties have provided Tax Certifications to the Escrow Agent, the Escrow Account shall not be invested as otherwise provided herein nor shall disbursements be made from the Escrow Account as otherwise provided at Article III. In the case of a person that is a "United States person" within the meaning of Section 7701(a)(30) of the Internal Revenue Code of 1986, as amended (the "*Code*"), an original IRS Form W-9 (or applicable successor form) will be provided. In the case of a person that is not a "United States person" within the meaning of Section 7701(a)(30) of the Code (hereinafter a "*foreign person*"), an original applicable IRS Form W-8ECI, W-

8IMY, W-8EXP or W-8BEN (or applicable successor form), along with any required attachments, will be provided to the Escrow Agent. As used herein "*Tax Certification*" shall mean an IRS form W-9 or W-8 as described above. Under current law, the applicable IRS Form W-8ECI, W-8IMY, W-8EXP or W-8BEN generally will expire every three (3) years and must be replaced with another properly completed and signed original sent to the Escrow Agent. A new original IRS Form W-8, indicating the relevant Escrow Account number, (or such other information or forms as required by law) must be delivered by each foreign person to, and received by, the Escrow Agent either prior to December 31st of the calendar year inclusive of the third (3rd) anniversary date of the date listed on the previously submitted form or as otherwise required by law.

10.2 The Escrow Agent will comply with any U.S. tax withholding or backup withholding and reporting requirements that are required by law.

10.3 Each Party hereby (i) represents and warrants each for itself that, as of the date this Agreement is made and entered into, the Escrow Account is not a Qualified Settlement Fund, Designated Settlement Fund, or Disputed Ownership Fund within the meaning of section 468B of the Code (and the regulations thereunder) and (ii) covenants that they shall not respectively take, fail to take or permit to occur any action or inaction, on or after the date this Agreement is made and entered into, that causes the Escrow Account to become such a Qualified Settlement Fund, Designated Settlement Fund, or Disputed Ownership Fund at any time.

10.4 The Parties agree that they are not relieved of their respective obligations, if any, to prepare and file information reports under Code Section 6041, and the Treasury regulations thereunder, with respect to amounts of imputed interest income, as determined pursuant to Code Sections 483 or 1272. The Escrow Agent shall not be responsible for determining or reporting such imputed interest.

ARTICLE XI

MISCELLANEOUS PROVISIONS

11.1 Each party hereto represents and warrants that such party has all necessary power and authority to execute and deliver this Agreement and to perform all of such party's obligations hereunder. This Agreement constitutes the legal, valid, and binding obligation of each party hereto, enforceable against such party in accordance with its respective terms, except as such enforceability may be limited by bankruptcy, insolvency, reorganization or other similar laws affecting the enforcement of creditors' rights generally and by general principles of equity, regardless of whether such enforceability shall be considered in a proceeding in equity or at law.

11.2 This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois and the parties hereto consent to jurisdiction in the State of Illinois and venue in any state or Federal court located in the City of Chicago.

11.3 Any bank or corporation into which the Escrow Agent may be merged or with which it may be consolidated, or any bank or corporation to whom the Escrow Agent may transfer a substantial amount of its escrow business, shall be the successor to the

Escrow Agent without the execution or filing of any paper or any further act on the part of any of the parties, anything herein to the contrary notwithstanding.

11.4 This Agreement may be amended, modified, and/or supplemented only by an instrument in writing executed by all parties hereto.

11.5 This Agreement may be executed by the parties hereto individually or in one or more counterparts, each of which shall be an original and all of which shall together constitute one and the same agreement. This Agreement, signed and transmitted by facsimile machine or pdf file, is to be treated as an original document and the signature of any party hereon, if so transmitted, is to be considered as an original signature, and the document so transmitted is to be considered to have the same binding effect as a manually executed original.

11.6 The headings used in this Agreement are for convenience only and shall not constitute a part of this Agreement. Any references in this Agreement to any other agreement, instrument, or document are for the convenience of the parties and shall not constitute a part of this Agreement.

11.7 As used in this Agreement, "*Business Day*" means a day other than a Saturday, Sunday, or other day when banking institutions in Chicago, Illinois are authorized or required by law or executive order to be closed.

11.8 This Agreement constitutes a contract solely among the parties by which it has been executed and is enforceable solely by the parties by which it has been executed and no other persons. It is the intention of the parties hereto that this Agreement may not be enforced on a third party beneficiary or any similar basis.

11.9 The parties agree that if any provision of this Agreement shall under any circumstances be deemed invalid or inoperative this Agreement shall be construed with the invalid or inoperative provisions deleted and the rights and obligations of the parties shall be construed and enforced accordingly.

11.10 No party hereto shall assign its rights hereunder until its assignee has submitted to the Escrow Agent (i) Patriot Act disclosure materials and the Escrow Agent has determined that on the basis of such materials it may accept such assignee as a customer and (ii) assignee has delivered an IRS Form W-8 or W-9, as appropriate, to the Escrow Agent which the Escrow Agent has determined to have been properly signed and completed. In addition, the foregoing rights to assign shall be subject, in the case of any party having an obligation to indemnify the Escrow Agent, to the Escrow Agent's approval based upon the financial ability of assignee to indemnify it being reasonably comparable to the financial ability of assignor, which approval shall not be unreasonably withheld.

11.11 Any claim against the Escrow Agent arising out of or relating to this Agreement shall be settled by arbitration in accordance with commercial rules of the American Arbitration Association. Arbitration proceedings conducted pursuant to this Section 11.11 shall be held in Chicago, Illinois.

11.12 Escrow Agent will treat information related to this Agreement as confidential but, unless prohibited by law, the Parties authorize the transfer or disclosure of any information relating to the Agreement to and between the subsidiaries, officers, affiliates and other representatives and advisors of Escrow Agent and third parties selected by any of them, wherever situated, for confidential use in the ordinary course of business, and further acknowledge that Escrow Agent and any such subsidiary, officer, Affiliate or third party may transfer or disclose any such information as required by any law, court, regulator or legal process.

The Parties will treat the terms of this Agreement, including any Fee Schedule, as confidential except on a "need to know" basis to persons within or outside such Party's organization (including affiliates of such Party), such as attorneys, accountants, bankers, financial advisors, auditors and other consultants of such party and its affiliates, except as required by any law, court, regulator or legal process and except pursuant to the express prior written consent of the other parties, which consent shall not be unreasonably withheld;

[SIGNATURES APPEAR ON THE FOLLOWING PAGE]

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

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By:



Name: Richard Bennett, M.D.

Title: President

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By:

Name:

Title:

Escrow Agent:

BANK OF AMERICA, NATIONAL ASSOCIATION

By:

Name:

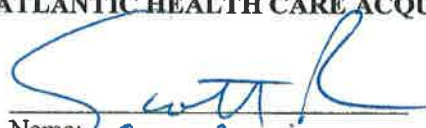
Title:

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

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

By: _____
Name: Richard Bennett, M.D.
Title: President

MID-ATLANTIC HEALTH CARE ACQUISITIONS, LLC

By:  _____
Name: Scott Ripkin
Title: Managing Member

Escrow Agent:

BANK OF AMERICA, NATIONAL ASSOCIATION

By: _____
Name:
Title:

EXHIBIT A

ESCROW AGENT FEE SCHEDULE

Set-Up Fee:	\$500.00
Tax Reporting Set-up Fee:	\$0.00
Annual Administration Fee:	\$3,500.00
Wire or Check Disbursement Fee:	\$20.00 per wire/check

THE SET-UP FEES AND FIRST YEAR'S ANNUAL ADMINISTRATION FEES ARE DUE UPON EXECUTION OF THE ESCROW AGREEMENT.*

Escrow Agent reserves the right to bill at cost for all out-of-pocket expenses, including out-of-pocket expenses in connection with the closing. Out-of-pocket expenses include, but are not limited to, professional services (e.g. legal or accounting), travel expenses, telephone and facsimile transmission costs, postage (including express mail and overnight delivery charges), and copying charges.

****(The Annual Administration Fee will be invoiced yearly in advance, without pro-ration for partial years. Wire and check disbursement fees will be invoiced on a quarterly basis.)***

[AN "EXHIBIT B" MUST BE COMPLETED AND EXECUTED FOR EACH PARTY TO THE AGREEMENT]

EXHIBIT B

Escrow Agreement Dated as of September __, 2014 by and among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association

Certificate of Authorized Representatives – Johns Hopkins Bayview Medical Center, Inc.

Name: Richard Bennett, M.D.

Name: Carl Francioli

Title: President

Title: VP, Finance

Phone: (410) 550-0781

Phone: (410) 550-0909

Facsimile: _____

Facsimile: _____

E-mail: rbennett@jhmi.edu

E-mail: cfranc@jhmi.edu

Signature: 

Signature: 

Fund Transfer / Disbursement Authority Level:

- ☒ Initiate
☒ Verify transactions initiated by others

Fund Transfer / Disbursement Authority Level:

- ☒ Initiate
☒ Verify transactions initiated by others

Name: _____

Name: _____

Title: _____

Title: _____

Phone: _____

Phone: _____

Facsimile: _____

Facsimile: _____

E-mail: _____

E-mail: _____

Signature: _____

Signature: _____

Fund Transfer / Disbursement Authority Level:

- ☐ Initiate
☐ Verify transactions initiated by others

Fund Transfer / Disbursement Authority Level:

- ☐ Initiate
☐ Verify transactions initiated by others

The Escrow Agent is authorized to comply with and rely upon any notices, instructions or other communications believed by it to have been sent or given by the person or persons identified above including without limitation, to initiate and verify funds transfers as indicated.

Johns Hopkins Bayview Medical Center, Inc.:

By: 

Richard Bennett, M.D.
President

Date: September 18, 2014

[AN "EXHIBIT B" MUST BE COMPLETED AND EXECUTED FOR EACH PARTY TO THE AGREEMENT]

EXHIBIT B

Escrow Agreement Dated as of September __, 2014 by and among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association

Certificate of Authorized Representatives – Mid-Atlantic Health Care Acquisitions, LLC

Name: Scott M. Rifkin

Title: Chief Executive Officer

Phone: (410) 960-7975

Facsimile: (410) 308-4999

E-mail: scottrifkinmd@gmail.com

Signature: 

Fund Transfer / Disbursement Authority Level:

- ☒ Initiate
☒ Verify transactions initiated by others

Name: Scott Potter

Title: Chief Financial Officer

Phone: (410) 308-2300, ext. 200

Facsimile: (410) 308-4999

E-mail: spotter@mid-atlantic.com

Signature: 

Fund Transfer / Disbursement Authority Level:

- ☒ Initiate
☒ Verify transactions initiated by others

Name: _____

Title: _____

Phone: _____

Facsimile: _____

E-mail: _____

Signature: _____

Fund Transfer / Disbursement Authority Level:

- ☒ Initiate
☒ Verify transactions initiated by others

Name: _____

Title: _____

Phone: _____

Facsimile: _____

E-mail: _____

Signature: _____

Fund Transfer / Disbursement Authority Level:

- ☐ Initiate
☐ Verify transactions initiated by others

The Escrow Agent is authorized to comply with and rely upon any notices, instructions or other communications believed by it to have been sent or given by the person or persons identified above including without limitation, to initiate and verify funds transfers as indicated.

Mid-Atlantic Health Care Acquisitions, LLC:

By: 

Name: SCOTT RIFKIN
Title: MANAGING MEMBER
Date: _____

EXHIBIT C
FORM OF TERMINATION NOTICE
[Date]

Bank of America, National Association
Global Custody and Agency Services
135 S. LaSalle Street
IL4-135-05-07
Chicago, Illinois 60603
Attention: Arlene Kaminski

NOTICE OF TERMINATION

Ladies and Gentlemen:

We refer you to that certain Escrow Agreement (the “*Agreement*”), dated as of September __, 2014, among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association, a photocopy of which is attached hereto. Capitalized terms used but not defined in this letter shall have the meanings given them in the Agreement.

We hereby notify you, in accordance with the terms and provisions of Article VII(a) of the Agreement, that we are terminating the Agreement. Accordingly, we request that you terminate the Agreement as of [•]¹. Those undertakings that, under the provisions of the Agreement, shall survive termination of the Agreement shall continue as provided therein. All Escrow Funds or items of property thereafter on deposit or held in the Escrow Account or by the Escrow Agent pursuant to the Agreement shall, concurrently with the termination of the Agreement, be delivered by, as applicable, federal wire transfer or nationally recognized overnight courier service as follows:

[Describe escrowed property or funds amount to be delivered]:

To *[Designate Party]*, at: *[insert fed wire instructions or physical address for overnight courier delivery]*.

Very truly yours,

JOHNS HOPKINS BAYVIEW MEDICAL
CENTER, INC.

MID-ATLANTIC HEALTH CARE
ACQUISITIONS, LLC

By: _____
Name:
Title:

By: _____
Name:
Title:

¹ Date should be not fewer than 2 Business Days after the date of this Notice.

ANNEX I
FORM OF DISBURSEMENT REQUEST

[Date]

Bank of America, National Association
Global Custody and Agency Services
135 S. LaSalle Street
IL4-135-05-07
Chicago, Illinois 60603
Attention: Arlene Kaminski

DISBURSEMENT REQUEST

Ladies and Gentlemen:

We refer you to that certain Escrow Agreement (the “*Agreement*”), dated as of September ____, 2014, among Johns Hopkins Bayview Medical Center, Inc., Mid-Atlantic Health Care Acquisitions, LLC, and Bank of America, National Association, as Escrow Agent. Capitalized terms used but not defined in this letter shall have the meanings given them in the Agreement.

Pursuant to the provisions of the Agreement, you are hereby directed to disburse funds held in the Escrow Account as follows:

(i) *[the amount to be disbursed],*

(ii) *[the date of disbursement],*

(iii) *[the recipient of the disbursement, and]*

(iv) *[the manner of disbursement and delivery instructions (including wiring instructions if applicable).]*

Very truly yours,

JOHNS HOPKINS BAYVIEW MEDICAL
CENTER, INC.

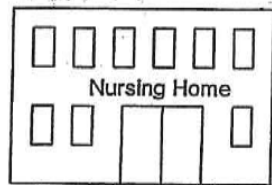
MID-ATLANTIC HEALTH CARE
ACQUISITIONS, LLC


By: _____
Name:
Title:

By: _____
Name:
Title:

EXHIBIT L

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



I wish I could get the
help I need in my own
home... 

**Get long term services and
supports in the community!**



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

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

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

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

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

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

This document is produced by the Maryland Department of Health and Mental Hygiene. For more information, please contact the Maryland Department of Health and Mental Hygiene at 1-800-637-4113.

Long Term Care Services in the Community

Please sign on the line below to certify that you have received the one page information sheet on long term care services in the community.

Signature

Date

Print Name

(This form must be kept in the resident's medical record.)

EXHIBIT M

AGE SPECIFIC CARE

All staff taking on-line class yearly.

COURSE DESCRIPTION

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

COURSE OBJECTIVES

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

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

OUTLINE

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

EXHIBIT N

Envisioning your future in a nursing home

Margaret P. Calkins, Ph.D.

President, IDEAS Inc.

Board Chair, IDEAS Institute

Founding member and Board Member, SAGE

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

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

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

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

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

History

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

Private vs. semi-private

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

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

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

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

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

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

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

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

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

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

Other Factors

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

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

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

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

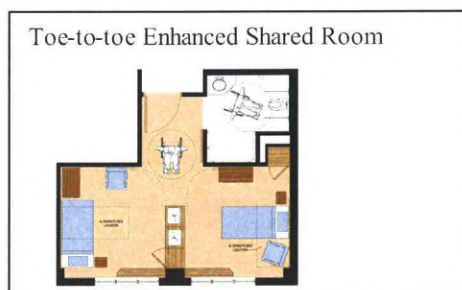
Medicaid, which is the largest payor source for nursing homes, in general will not pay more for a private room. However, in Michigan, the legislature approved a \$5/day higher reimbursement for nursing homes that constructed private rooms. Even with a higher reimbursement of just \$5/day, the construction/capital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

Staff Factors

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

Other Alternatives

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



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

Summary

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

(3.07) of acquiring an infection when living in a shared room over being in a private room (Drinka, Krause, Nest, Goodman, & Gravenstein, 2003), it is likely that these healthcare costs might be recouped within a few years with private rooms.

Unfortunately, because nursing homes do not pay for the costs of these hospitalizations, the potential cost savings serve as less of an incentive to them. Policy makers, however, should be concerned with the potential for significant cost savings. The savings to Medicare of these prevented hospitalizations is significant. More research that specifically examines rates of infections and hospitalizations by room type (private, traditional shared or enhanced shared) is needed.

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

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

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

Recommendations

Recommendations

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

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

References

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EXHIBIT O

Nelson•Tremain Partnership

ARCHITECTURE AND DESIGN FOR AGING

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Household Models for Nursing Home Environments

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

Form Follows Regulation

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

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

Prescriptive requirements led to a situation where architects and designers used the regulations as the basis for all planning and design decisions. Due to cost constraints, minimum requirements quickly became maximum allowable quantities and sizes of facilities, and in some jurisdictions, these maximums were mandated. Such mandates not to exceed particular size requirements grew from a fear that the state government may need to take over and operate poorly performing facilities. It only makes common sense that a facility with more square feet per patient is more costly to operate than a smaller facility.

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

Hierarchy of Space

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

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

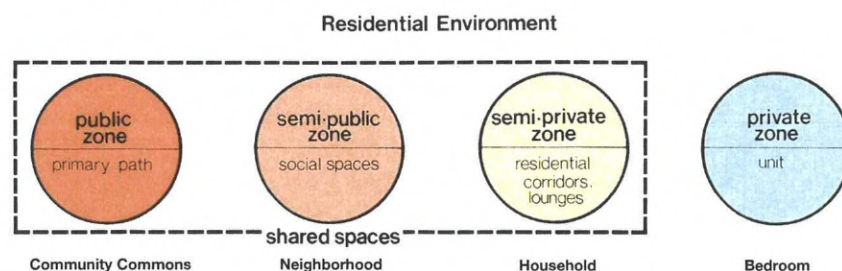


Figure 1

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

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

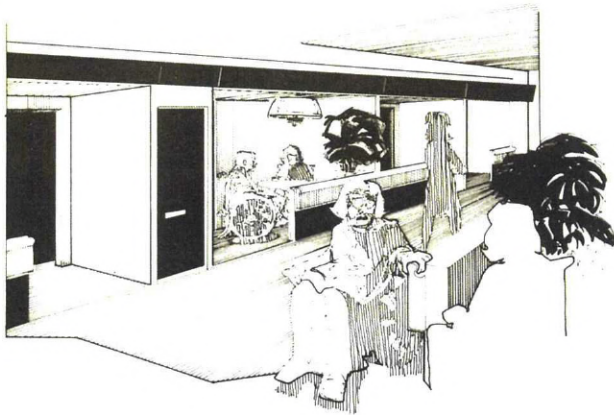
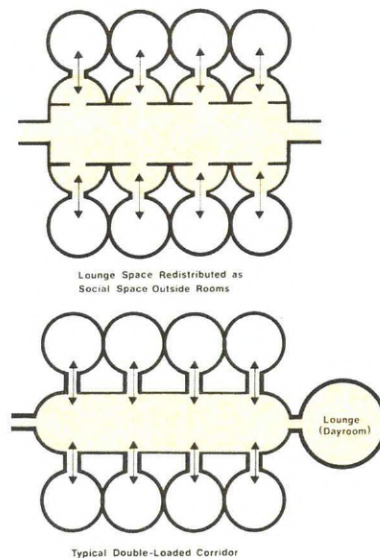


Figure 2

Part IV: Design



Designing the Open Nursing Home
Joseph A. Koncelik, 1976

Quality of Life

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

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

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

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

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

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

To Live in Fullness

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

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

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

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

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

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

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

The Quality of Experience in Everyday Activities

Based on daytime activities reported by representative adults and teenagers in recent U.S. studies, the typical quality of experience in various activities is indicated as follows:

- negative; - very negative; • average or neutral; + positive; ++ very positive

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

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

Figure 3
(Csikszentmihalyi 1997)

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

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

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

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

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

The Nursing Home - As Institution

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

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

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

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

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

The Household - A Relationship-Enabling Environment

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

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



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

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



Household Plan

Figure 5

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

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

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



Living Room at Creekview

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Dining Room at Creekview

© Nelson•Tremain



Backyard at Creekview

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

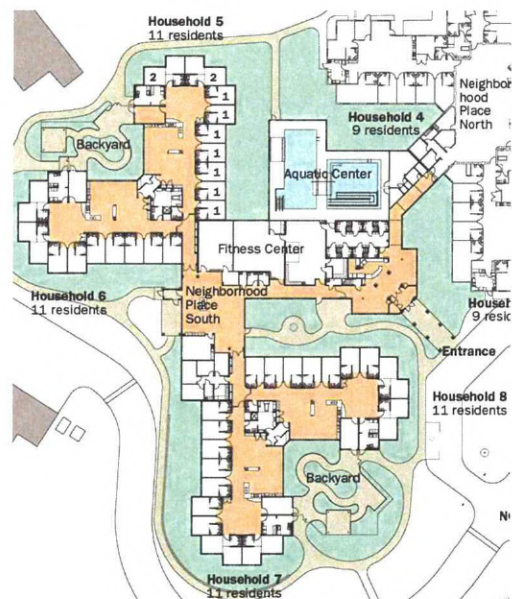


Figure 6

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

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

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

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

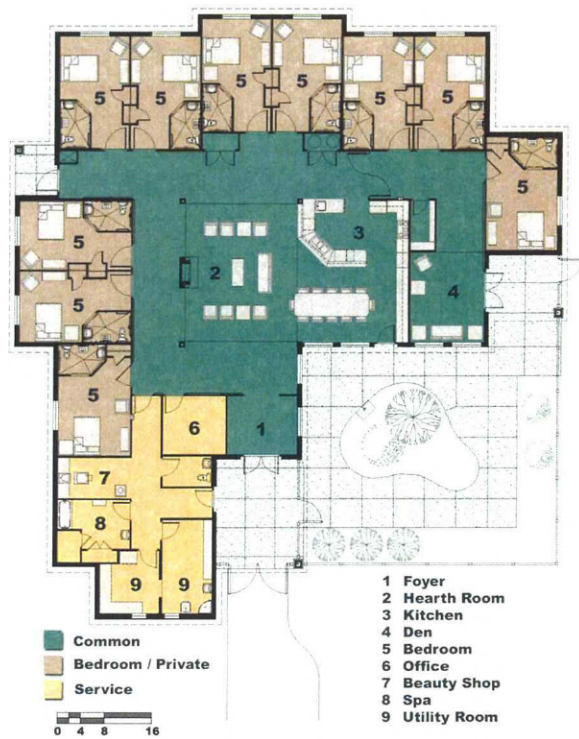


Figure 7

(DESIGN 2004)

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



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



Green House® Hearth
(DESIGN 2004)

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



Household Plan

(Figure 8)

© Nelson•Tremain Partnership

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

Household Size

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

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

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

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

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

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

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

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

Flexibility for a Variety of Population Groups

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

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

Deinstitutionalize Clinical Resources

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



Creekview - Medicine Island (foreground) and Staff Work Desk

Creekview

- Bathing Spa with Fireplace

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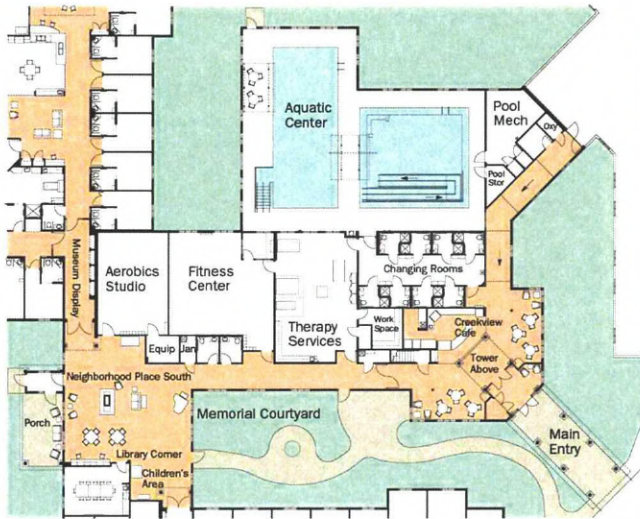
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The Neighborhood - Enabling Relationships within Community

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

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

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



(Figure 9)

South

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Creekview - Neighborhood Place

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Creekview - Aquatic Center

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Creekview Café

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Household Models and the Regulatory Mileau

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

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

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

Overlapped, Confusing and Contradictory Regulatory Jurisdictions

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

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

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

Interpretations Approved in Plan Review are not Recognized at Final Inspection

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

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

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

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

Kitchen Spaces Open to Corridors

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

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

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

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

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

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

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

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

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

Protection against Non-Fire Dangers in the Kitchen

In addition to fire safety, there are many regulations that are intended to protect residents against perceived or real dangers in

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

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

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

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

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

Laundry Facilities

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

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

Handrails

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

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

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

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

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

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

Protrusions into the Corridor Width

There are conflicting requirements as to the allowable distance elements may protrude into the width of corridors. NFPA 101, LSC allows only 3 1/4" protrusion, while the Americans with Disabilities Act Architectural Guidelines (ADAAG) allows 4" for items within 6'-8" of the floor level. Unfortunately many industries, such as lighting manufacturers utilize ADAAG standards in design and manufacture of products. Compliance with NFPA 101, LSC precludes the use of typical elements of home, including furniture, plants or wall mounted, sconce lighting fixtures.

Many CMS regional offices have interpreted that the 3 1/4" protrusion applies to all corridors, regardless of width, meaning that in the case of corridors that exceed minimum width

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

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

Eight-Foot Corridor Width

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

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

Three Foot - Eight Inch Wide Administrative Office Doors

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

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

Direct Line-of-Sight as Control over the Corridor

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

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

Distance to the "Nurses' Station"

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

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

Wired and Wireless Call Systems (UL 169)

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

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

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

Security against Residents leaving Unescorted vs. Fire Safety

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

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

Security for Outdoor Spaces

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

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

Smoke Compartment Requirements

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

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

Accessibility Standards

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

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

Sliding Doors in Low Occupancy Areas

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

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

Separation between Nursing Home and Daycare Occupancies

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

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

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

Allowance for Use of Personal Furniture

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

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

Standards for Small-scale Environments

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

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

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

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EXHIBIT P



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April 10, 2015

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

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

To Whom It May Concern:

I am Stephen N. Davis, MBBS, the Theodore E. Woodward Endowed Chair and the Professor and Chairman of the Department of Medicine at the University of Maryland School of Medicine. In my capacity, I also am Co-Director of the University of Maryland Clinical Translational Science Institute and the Program Director of the University of Maryland General Clinical Research Center.

I am writing to express my strong support for the proposed construction of a new comprehensive care facility to be located at 300 W. Fayette Street in downtown Baltimore. I have had several discussions with Dr. Scott Rifkin, CEO of Mid-Atlantic Health Care, LLC, about the project and am excited about continuing to explore the opportunity to partner with Mid-Atlantic Health Care, LLC to integrate this facility into our clinical pathways to create a state of the art post-acute care center focused on avoiding hospitalizations and lowering hospital re-admissions.

In my opinion, the possible collaboration and integration envisioned between the new facility and our clinical pathways would be unique in Baltimore City. Further, we believe this relationship will help further our responsibilities under the Maryland Medicare Waiver.

Respectfully Submitted,

Stephen N. Davis, MBBS, FRCP, FACP

cc: Scott Rifkin, MD; Mid-Atlantic Health Care, LLC



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Davidge Hall is the historical symbol of the **University of Maryland School of Medicine** - America's oldest public medical school, founded in 1807.

EXHIBIT Q



University of Maryland Medical System

Proposal to the Health Services Cost Review Commission:

Risk Construct for the Management of Medicare FFS Total Cost of Care

in Partnership with Mid-Atlantic Health Care

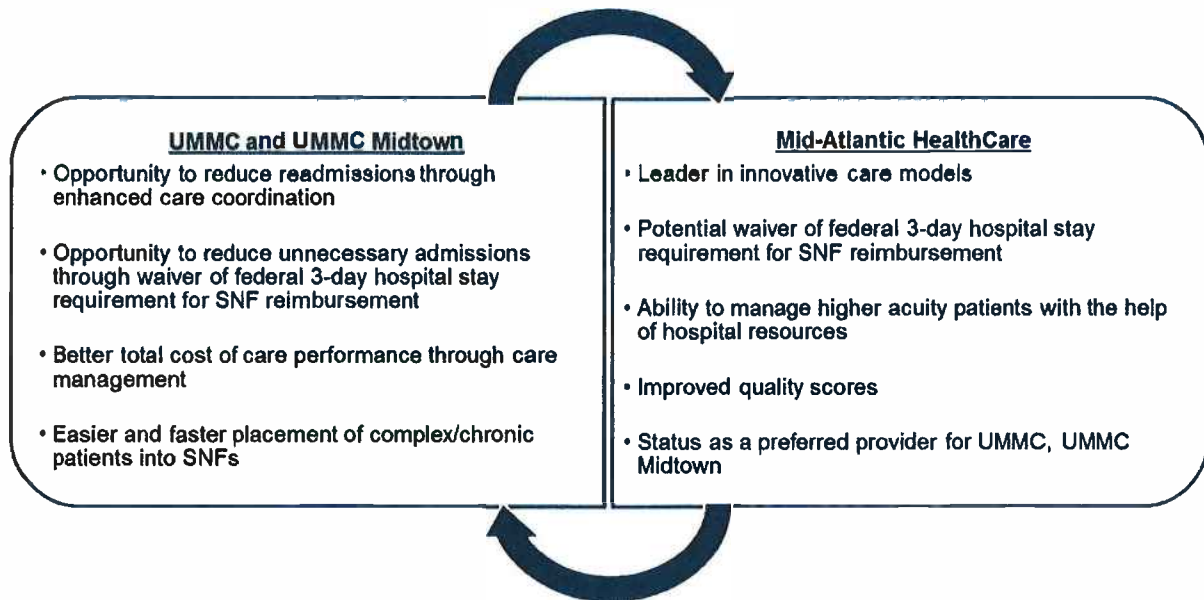
The purpose of this letter is to outline a proposal on behalf of two of its member hospitals, University of Maryland Medical Center (“UMMC”) and UMMC Midtown Campus (“UMMC Midtown”), to take on risk for Medicare FFS Total Cost of Care for its patients that are discharged to Mid-Atlantic Health Care’s (“MAHC”) proposed new Skilled Nursing Facility. UMMS proposes a three-year pilot of this program, to be effective immediately upon opening of the new MAHC building.

Mid-Atlantic Health Care has submitted a Certificate of Need (“CON”) application to the Maryland Health Care Commission, (“MHCC” or the “Commission”) for an 80-bed nursing home at 300 West Fayette Street in downtown West Baltimore. University of Maryland Medical System (“UMMS”) is interested in partnering with MAHC to control Medicare FFS TCOC on all patients discharged from University of Maryland Medical Center and UMMC Midtown Campus to MAHC’s proposed new facility, Baltimore Nursing and Rehabilitation (“BNR”), d/b/a “Restore Health.”

UMMC and UMMC Midtown (“the Hospitals”), two acute care hospitals in Baltimore City, are part of the University of Maryland Medical System, a nonprofit corporation committed to the triple aim of health care and the continuation of the Maryland Demonstration Model. As the state looks to progress to Phase II of the Demonstration Model, UMMS recognizes the importance of provider collaboration for managing the growth in Medicare FFS TCOC. While currently incented under the Global Budget Revenue (“GBR”) construct to reduce avoidable hospital utilization and provide high quality, cost efficient care, UMMS sees the opportunity for managing costs along the entire care spectrum by aligning incentives with post-acute providers.

Restore Health will be located within close proximity to UMMC and UMMC Midtown and will feature facilities for the care and rehabilitation of post-acute patients, particularly medically complex patients and those currently experiencing long discharge delays. As such, UMMS anticipates that its patients requiring skilled nursing care following discharge will consider Restore Health when selecting a post-acute provider. Since SNFs are paid on a fee-for-service (“FFS”) basis, UMMS and BNR operate under opposing financial incentives. Recognizing that hospitals will be expected to take responsibility for TCOC under Phase II of the Demonstration Model, UMMS views a partnership with MAHC as an effective vehicle through which both parties can address TCOC of the shared population through a set of mutually beneficial incentives:

Incentive Feedback Loop

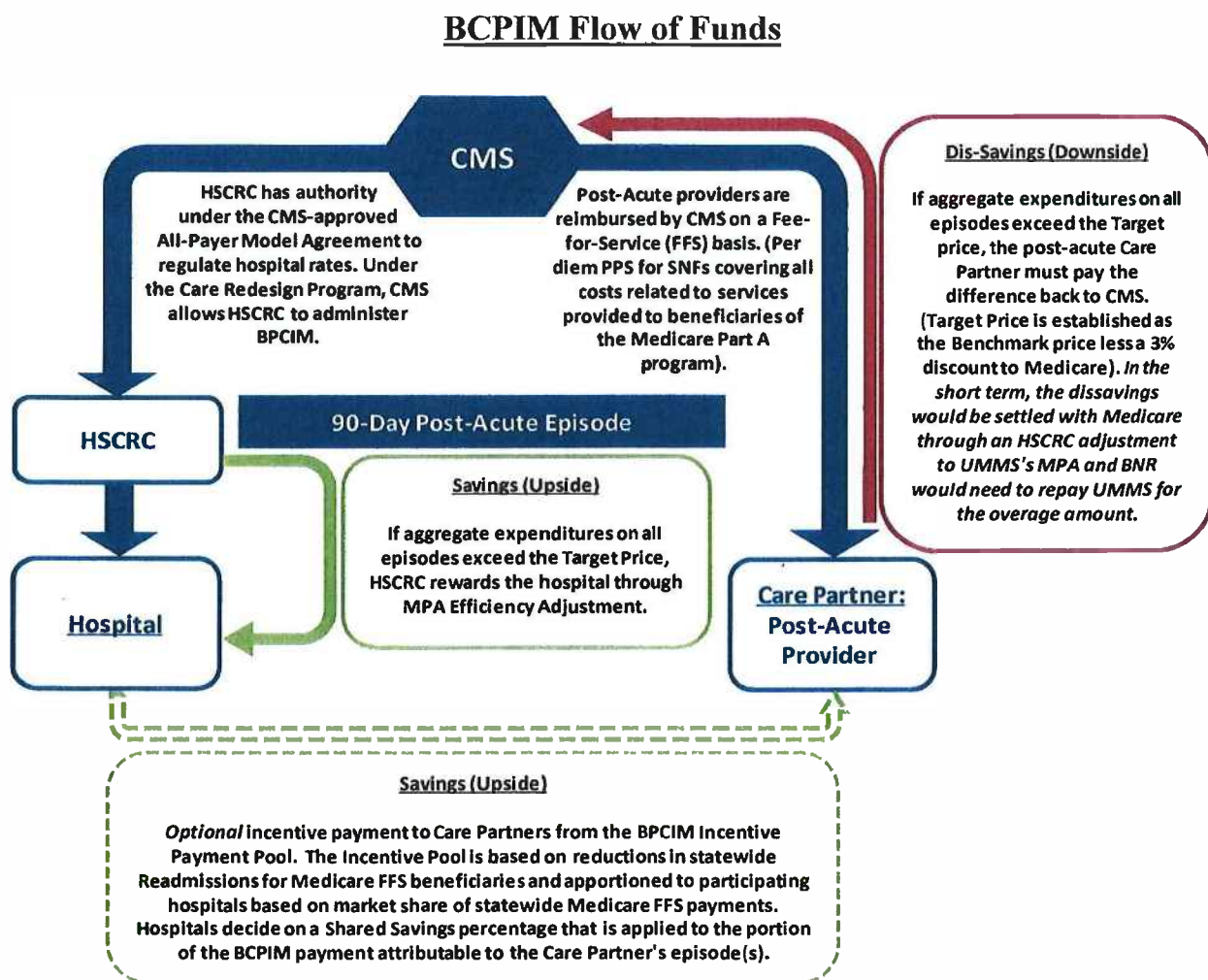


UMMS proposes to participate in the HSCRC’s proposed Bundled Payments for Care Initiative in Maryland (“BPCIM”), wherein UMMC and UMMS Midtown will act as the Conveners, and Restore Health will be a Non-Convener Participating Care Partner. This BPCIM construct is modelled on CMS’s Bundled Payments for Care Initiative Advanced (“BPCI-A”), wherein the episode of care will include post-acute care at BNR, as well as all related post-acute services during the 90 days after hospital discharge from UMMC or UMMC Midtown. An episode will be triggered by a Medicare beneficiary’s acute care hospital stay and begin at the initiation of post-acute care services starting on the day of discharge from hospital. UMMS and BNR will work together to select high volume episodes from the list of 29 qualifying inpatient episodes offered. BNR commits to ensuring that at least 80% of its cases are included in a BCPIM arrangement, annually. Due to issues with price distortions related to the fixed-cap nature of the GBR, hospital costs are excluded from this model. However, recognizing the relationship between post-acute care and hospital readmissions, BNR recognizes that it may be held responsible for a portion of readmission costs in each episode.

UMMS commits to the requirements of the Care Redesign Participation (“CRP”) Agreement, including the implementation of BPCIM interventions, the collection and reporting of all requisite quality measures, and the use of Certified EHR Technology (“CEHRT”).

As a Care Partner, BNR commits to the 3% Target Price discount to the Benchmark Price, which will produce immediate savings to Medicare. In addition, in the event that the actual Medicare FFS expenditures exceed the Target price, BNR will be responsible for the excess Medicare expenditures.

When the state develops a participation agreement directly with Medicare for non-hospital providers, excess expenditures can be collected from BNR or its successor organization. Until such time, the excess expenditures will be adjusted through UMMS's MPA efficiency adjustment and BNR will reimburse UMMS. In the event that actual Medicare FFS expenditures are lower than the Target Price, UMMS will receive a reward payment through the MPA efficiency adjustment. Any incentive payments between UMMS and BNR will be worked out in a separate sub-agreement, with the details provided to the HSCRC in Section 5 of the CRP Agreement.



Given this bundle arrangement, UMMS anticipates that patients in this Arrangement will experience superior cost and quality performance compared to patients not included in an episode-based payment system. This enhanced performance will contribute to further reducing Medicare FFS TCOC in West Baltimore City. Further, UMMS will be subject to the Medicare Performance Adjustor ("MPA"), placing it at risk for Medicare FFS TCOC in this region beyond what it is committing to in this Agreement.

Further, BNR recognizes the potential for its new facility to generate incremental use rate growth for SNF services. While participation in the BPCIM construct will limit costs on a per episode basis, it is possible that an increase in SNF stays in the area could generate unanticipated growth in the Total Cost of Care for the area. To avoid any concerns regarding growth in costs related to SNF use rate growth, UMMS and BNR commit to monitoring how the use of the new BNR facility, including backfill in other area facilities, contributes to the growth of total Medicare FFS or Medicaid utilization and cost on an aggregate basis in the zip codes that constitute the UMMS/BNR combined primary service area. This will include comparison of changes in SNF days and cost per Medicare beneficiary in the identified zip codes to Maryland and national benchmarks. Changes in Medicaid SNF days will also be measured and evaluated in the service area, including changes to competitor facilities.

In the event that growth in the TCOC for this area exceeds a benchmark established by the HSCRC in collaboration with UMMS, UMMS and BNR are amenable to working with the HSCRC, the State, and/or Medicaid on a corrective action plan to bring cost and utilization growth back below the benchmark. Upon documentation of excess growth, the HSCRC or State may provide a notice of required corrective action plan. Upon receipt of such notice, UMMS and BNR will have 45 days to submit a corrective action plan. If excess cost is not eliminated within 365 days, HSCRC may utilize the MPA to collect excess growth from UMMS. UMMS can then collect excess growth from BNR.

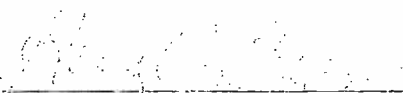
Recognizing the potential increase to Medicare FFS TCOC associated with a new SNF in its service area, UMMS seeks approval from the HSCRC for this proposal as an innovative way to facilitate new partnerships across providers while controlling the rise of non-hospital costs to its patients. As such, UMMS hopes that including the new MAHC facility in its preferred provider network will incent MAHC to work with UMMS on the management of its shared patients, improving health outcomes, reducing readmissions and targeting appropriate length of stay in both the hospital and SNF setting

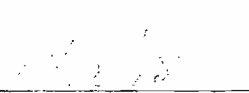
There is a clear opportunity to focus on reducing Medicare FFS TCOC growth in this area as the state moves to Phase II of the Demonstration Model. UMMS and Restore Health, two key players in this market, seek to collaborate under this unique risk agreement to control costs for this area.

With MPA structures already in place, UMMS can efficiently apply its existing population health and care management strategies to this population; incentive alignment with Restore Health under this risk agreement will augment UMMS's efforts to manage costs for this population.

In addition to approval of this risk construct, UMMS seeks to work with the HSCRC and CRISP on optimizing available TCOC claims data for purposes of monitoring these patients in real time, tracking performance on TCOC and quality metrics for this patient subset, and calculating rewards and penalties.

The University of Maryland Medical System appreciates the opportunity to propose this risk construct on behalf of University of Maryland Medical Center and UMMC Midtown Campus and looks forward to working with HSCRC staff on this innovative risk construct.

Signature: 

Date: 

Henry J. Franey, MBA
Executive Vice President & Chief Financial Officer
University of Maryland Medical System

Signature: 

Date: 

Scott Rifkin, MD
Chairman
Mid-Atlantic Health Care

EXHIBIT R

**Average Annual Bed Occupancy Rate and Average Annual Licensed
Nursing Home Bed Capacity by Jurisdiction and Region:
Maryland, Fiscal Years 2014 – 2016**

Region	Jurisdiction	Average Annual Bed Occupancy Rate (%)*			Average Annual Bed Capacity **		
		FY 2014	FY 2015	FY 2016	FY 2014	FY 2015	FY 2016
Western Maryland		91.0	89.7	87.9	4,315	4,329	4,362
	Allegany	88.8	88.8	86.8	904	903	907
	Carroll	91.2	88.7	87.1	921	921	921
	Frederick	90.1	89.1	88.6	1,062	1,064	1,080
	Garrett	93.4	95.7	89.8	313	309	316
	Washington	92.9	90.3	88.1	1,114	1,133	1,138
Montgomery County	Montgomery	87.3	87.1	87.0	4,527	4,506	4,456
Southern Maryland		92.6	91.4	91.6	4,060	4,137	4,020
	Calvert	85.4	92.0	83.4	302	302	302
	Charles	93.5	88.1	91.5	418	482	489
	Prince George's	93.3	91.6	92.2	2,775	2,790	2,666
	St Mary's	92.0	92.8	92.9	565	563	563
Central Maryland		89.9	89.9	89.8	12,196	12,237	12,053
	Anne Arundel	86.3	88.6	89.7	1,751	1,758	1,760
	Baltimore City	91.2	90.5	90.3	3,724	3,749	3,643
	Baltimore County	89.7	89.9	89.2	5,397	5,393	5,315
	Harford	92.9	91.4	91.2	770	769	769
	Howard	89.7	89.1	89.6	553	568	566
Eastern Shore		86.5	83.4	83.8	2,572	2,605	2,552
	Caroline	92.0	82.2	85.4	187	187	187
	Cecil	84.0	78.6	81.7	429	454	454
	Dorchester	87.6	86.7	87.3	242	240	240
	Kent	75.7	80.0	80.4	228	228	228
	Queen Anne's	93.7	88.7	82.3	110	120	120

	Somerset	91.6	86.4	88.6	211	211	211
	Talbot	90.2	89.7	86.6	260	260	260
	Wicomico	84.9	80.6	82.0	607	613	550
	Worcester	88.3	87.6	83.5	297	292	302
Maryland Total		89.7	89.0	88.7	27,669	27,814	27,443

* Average Annual Bed Occupancy Rate is the ratio of total nursing home patient days to total available licensed nursing home bed days, which excludes temporarily delicensed beds

.** Average Annual Bed Capacity is calculated by dividing the total available nursing home bed days in each year by 365 days in FY 2014 and FY 2015 and by 366 days in the FY 2016 leap year.

Source: Maryland Health Care Commission, 2016 Long Term Care Survey, 2016 Nursing Home Bed Inventory Records; Maryland Medical Assistance Program, unaudited 2016 cost reports.

Note: Charlotte Hall (St. Mary's) utilization and bed capacity is included in all years.

Published in *Maryland Register*, Volume 45, Issue 16, August 3, 2018

EXHIBIT S

Restore Health

Reasonableness Test for Projected Volume

Based on UMMS Demand in Baltimore City: UMMC and UMMC Midtown

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

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

Population B: Complex medical; special resources/capabilities required

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

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

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

Population D: PQIs: Avoidable Hospital Admissions

Patient Population	ESTIMATED CURRENT PLACEMENTS (2014-2015)			PROJECTED VOLUME FOR RESTORE HEALTH (2018)				
	Total UMMC Placements	Total Midtown Placements	Projected Capture Rate	Total Discharges	ALOS	Total Days	ADC Demand	Demand for Beds @ 90% Occupancy
Subtotal, PQIs, Direct Admits, Non-Medicare	629	240	25%	217	4	869	2	3
Subtotal, PQIs, Direct Admits, Medicare	600	274	50%	437	4	1,748	5	5
TOTAL (D), New Direct Admits to Nursing Homes	1,229	514	50%	654	4	2,617	7	8

Grand Total, Restore Health, with 3 day waiver

1,089	25	27,605	76	84
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Grand Total, Restore Health, absent 3 day waiver

652	40	25,857	71	79
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Sources:

[1] UMMC Placements and Midtown Placements: Estimates from caseworkers at each hospital

[2] PQI discharges: HSCR Discharge Abstract Database, FY2014

[3] Out of area placements based on Long Term Care Minimum Dataset provided by the MHCC

EXHIBIT T

Prevention Quality Indicators Overview

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

The PQIs can be used as a "screening tool" to help flag potential health care quality problem areas that need further investigation; provide a quick check on primary care access or outpatient services in a community by using patient data found in a typical hospital discharge abstract; and, help public health agencies, State data organizations, health care systems, and others interested in improving health care quality in their communities.

With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided. Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community. Because the PQIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to provide a window into the community — to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.

http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

PQI Discharges at Baltimore City Hospitals
Fiscal Year 2014

Medicare Patients Only

	UMMC Midtown Campus				University of Maryland Medical Center				All Other City Hospitals				Total			
	Cases	Avg. Length of Stay	Avg. Charge per Case		Cases	Avg. Length of Stay	Avg. Charge per Case		Cases	Avg. Length of Stay	Avg. Charge per Case		Cases	Avg. Length of Stay	Avg. Charge per Case	
MS-DRG																
PQI 08 Heart Failure	75	5	\$16,495		187	6	\$16,210		2,892	5	\$13,152		3,154	5	\$13,413	
PQI 05 COPD or Asthma in Older Adults	71	4	13,838		83	6	36,444		1,696	4	11,546		1,850	4	12,751	
PQI 11 Bacterial Pneumonia	41	4	12,272		44	5	14,338		1,131	5	12,356		1,216	5	12,425	
PQI 12 Urinary Tract Infection	12	4	11,931		67	4	10,522		1,028	4	9,027		1,107	4	9,149	
PQI 03 Diabetes Long-Term	29	5	20,086		101	7	55,632		782	5	20,157		912	6	24,083	
PQI 10 Dehydration	9	4	13,115		43	3	10,197		624	4	9,398		676	4	9,498	
PQI 07 Hypertension	10	4	12,801		34	3	8,421		320	3	8,828		364	3	8,899	
PQI 01 Short-term Diabetes	13	4	13,754		14	6	18,728		230	4	11,365		257	4	11,887	
PQI 16 Lower Extremity Amputation among Patients with Diabetes	10	14	71,755		16	18	80,985		157	13	49,630		183	13	53,581	
PQI 13 Angina without Procedure	-	-	-		8	2	9,936		72	2	8,713		80	2	8,836	
PQI 14 Uncontrolled Diabetes	3	8	8,315		1	5	13,039		56	4	8,306		60	4	8,385	
PQI 15 Asthma in Younger Adults	1	4	15,790		2	1	5,405		21	3	8,297		24	3	8,368	
Total	274	5	\$16,903		600	6	\$25,662		9,009	5	\$12,986		9,883	5	\$13,865	

Non-Medicare Patients

	UMMC Midtown Campus				University of Maryland Medical Center				All Other City Hospitals				Total			
	Cases	Avg. Length of Stay	Avg. Charge per Case		Cases	Avg. Length of Stay	Avg. Charge per Case		Cases	Avg. Length of Stay	Avg. Charge per Case		Cases	Avg. Length of Stay	Avg. Charge per Case	
MS-DRG																
PQI 05 COPD or Asthma in Older Adults	47	2	10,534		93	3	13,820		1,513	3	9,702		1,653	3	9,958	
PQI 08 Heart Failure	33	4	14,790		159	5	15,257		1,328	5	12,576		1,520	5	12,905	
PQI 11 Bacterial Pneumonia	22	3	11,991		87	4	12,684		930	4	11,068		1,039	4	11,223	
PQI 03 Diabetes Long-Term	40	4	15,427		71	5	50,577		819	5	16,933		930	5	19,437	
PQI 01 Short-term Diabetes	37	3	10,143		48	3	8,102		638	3	9,221		723	3	9,194	
PQI 12 Urinary Tract Infection	6	2	8,015		51	4	12,869		537	3	8,154		594	3	8,557	
PQI 10 Dehydration	12	3	10,032		37	5	16,815		418	3	9,266		467	3	9,883	
PQI 07 Hypertension	21	3	12,587		41	2	9,561		400	2	7,607		462	2	8,007	
PQI 15 Asthma in Younger Adults	12	2	7,450		16	2	7,331		292	2	7,452		320	2	7,446	
PQI 16 Lower Extremity Amputation among Patients with Diabetes	5	9	30,011		11	13	50,641		75	12	42,679		91	12	42,946	
PQI 14 Uncontrolled Diabetes	4	3	7,291		2	4	10,555		77	2	5,976		83	2	6,150	
PQI 13 Angina without Procedure	1	3	11,015		13	2	9,000		64	2	9,155		78	2	9,153	
Total	240	3	12,259		629	4	17,929		7,091	4	11,161		7,960	4	11,730	

Notes:

- [1] PQI 02 Perforated Appendix excluded from the analysis
- [2] All other city hospitals include St. Agnes, Sinai, Mercy, Johns Hopkins, Johns Hopkins Bayview, Bon Secours, MedStar Harbor, MedStar Good Samaritan, MedStar Union Memorial

Summary of Cases with Prevention Quality Indicators
Baltimore City Hospitals
Fiscal Year 2014

Medicare Patients Only

MS-DRG	UMMC Midtown Campus	University of Maryland Medical Center	Mercy Medical Center	Johns Hopkins Hospital	St. Agnes Hospital	Sinai Hospital	Bon Secours Hospital	MedStar Union Memorial Hospital	Johns Hopkins Bayview Medical Center	MedStar Harbor Hospital Center	MedStar Good Samaritan Hospital	Total
PQI 08 Heart Failure	75	387	191	444	407	468	59	308	447	176	392	3,154
PQI 05 COPD or Asthma in Older Adults	71	83	128	153	308	188	100	165	297	171	186	1,850
PQI 11 Bacterial Pneumonia	41	44	75	117	293	144	27	128	163	73	111	1,216
PQI 12 Urinary Tract Infection	12	67	82	98	236	179	25	65	143	65	135	1,107
PQI 03 Diabetes Long-Term	29	101	55	165	89	127	19	63	127	36	101	912
PQI 10 Dehydration	9	43	41	88	102	138	15	30	93	24	93	676
PQI 07 Hypertension	10	34	11	49	59	54	10	21	42	9	65	364
PQI 01 Short-term Diabetes	13	14	9	35	31	47	9	21	32	15	31	257
PQI 16 Lower Extremity Amputation among Patients with Diabetes	10	16	15	24	18	18	5	20	26	6	25	183
PQI 13 Angina without Procedure	-	8	8	12	8	5	2	3	20	5	9	80
PQI 14 Uncontrolled Diabetes	3	1	4	5	11	12	-	6	8	2	8	60
PQI 15 Asthma in Younger Adults	1	2	-	4	1	3	1	4	2	3	3	24
Total	274	600	619	1,194	1,563	1,383	272	834	1,400	585	1,159	9,883

Non-Medicare Patients

MS-DRG	UMMC Midtown Campus	University of Maryland Medical Center	Mercy Medical Center	Johns Hopkins Hospital	St. Agnes Hospital	Sinai Hospital	Bon Secours Hospital	MedStar Union Memorial Hospital	Johns Hopkins Bayview Medical Center	MedStar Harbor Hospital Center	MedStar Good Samaritan Hospital	Total
PQI 05 COPD or Asthma in Older Adults	47	93	112	244	224	178	114	114	239	353	135	1,653
PQI 08 Heart Failure	33	159	79	338	138	150	64	110	220	69	160	1,520
PQI 11 Bacterial Pneumonia	22	87	73	172	169	90	50	108	132	61	75	1,039
PQI 03 Diabetes Long-Term	40	71	58	191	121	128	39	65	100	32	85	930
PQI 01 Short-term Diabetes	37	48	35	138	110	103	22	44	86	38	62	723
PQI 12 Urinary Tract Infection	6	51	75	105	84	62	28	29	71	27	56	594
PQI 10 Dehydration	12	37	32	141	56	45	14	17	53	14	46	467
PQI 07 Hypertension	21	41	14	82	64	58	11	45	37	22	67	462
PQI 15 Asthma in Younger Adults	12	16	23	68	44	49	17	20	32	17	22	320
PQI 16 Lower Extremity Amputation among Patients with Diabetes	5	11	8	15	11	5	2	9	10	1	14	91
PQI 14 Uncontrolled Diabetes	4	2	6	9	10	20	2	10	9	5	6	83
PQI 13 Angina without Procedure	1	13	8	14	4	4	10	2	14	4	4	78
Total	240	629	523	1,517	1,035	892	373	573	1,003	443	732	7,960

Notes:

- [1] PQI 02 Perforated Appendix excluded from the analysis
- [2] Assumption of an average LOS of 4 days per patient at Mid-Atlantic
- [3] All other city hospitals include St. Agnes, Sinai, Mercy, Johns Hopkins, Johns Hopkins Bayview, Bon Secours, MedStar Harbor, MedStar Good Samaritan, MedStar Union Memorial

EXHIBIT U



Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

April 3, 2015

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

To whom it may concern:

We are the accountants and auditors for Mid-Atlantic Health Care, LLC and its subsidiaries, including Mid-Atlantic Health Care Acquisitions, LLC and Baltimore Nursing and Rehabilitation, LLC and Baltimore Nursing and Rehabilitation Realty, LLC. We have been the accountants and auditors for the consolidated entity for over 10 years. Mid-Atlantic Health Care (the Company) has asked us to comment on their ability to provide the \$4.4 million in equity and obtain the \$14.0 million in necessary financing to construct and operate the proposed 80 bed state of the art skilled nursing facility in Baltimore City.

Mid-Atlantic Health Care et al owns and operates approximately 18 skilled nursing facilities in the Mid-Atlantic region. Based on our review of the financial statements and conditions of the Company, the Company has been profitable and is expected to continue to increase its profitability. The Company has a very healthy balance sheet and presently has the ability to provide the \$4.4 million in equity and obtain the necessary financing for the above referenced proposed project.

Please contact the undersigned if you have any questions regarding this communication.

Very truly yours,

Leonard Sacks, CPA, CVA, CFF, CIRA, CDBV

Baltimore
Greater Washington, D.C.
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Suite 300
Owings Mills, Maryland 21117
410.363.3200

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EXHIBIT V



Bruce D. McLean
Commercial Banking
307 International Circle
Suite 600
Hunt Valley, MD 21030-1376
410-316-0273
Bruce.McLean@susquehanna.net

April 8, 2015

Scott M. Rifkin, M.D.
Mid-Atlantic Health Care, LLC
1922 Greenspring Drive
Timonium, MD 21093

Re: Proposed 80 Bed Nursing Home – Baltimore City, MD

Dear Dr. Rifkin:

We understand that you are seeking Certificate of Need approval from the Maryland Health Care Commission to construct a new 80 bed skilled nursing facility in Baltimore City, MD. The project will be undertaken by a new limited liability company with common ownership to be formed and under control of Mid-Atlantic Health Care, LLC. We welcome the opportunity to consider your request for us to provide the construction and acquisition financing for this \$19,500,000 project.

Accordingly, Susquehanna Bank would be willing to consider providing the financing necessary to fund this project. If we were to ultimately agree to provide the necessary financing, our commitments typically have a life of 90 days.

Please understand that this correspondence is not to be construed as a commitment of any kind to provide the capital to fund this project. As you know, loan approvals require formal committee approval, which would be communicated to you in writing. Our due diligence process would be extensive, and would include Certificate of Need, building plans, specifications, pro-formas, budgets and additional financial information.

Please let us know if we can be of further assistance, and we look forward to working with you on this project.

Best regards,

Yours truly,

Bruce D. McLean

EXHIBIT W



Medicare Shared Savings Program

SKILLED NURSING FACILITY 3-DAY RULE WAIVER

Guidance

January 2019
Version #7



MEDICARE
SHARED SAVINGS
PROGRAM

Revision History (from version 6 to version 7)

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
7	January 2019	Updated throughout to consider Medicare Shared Savings Program “Pathways to Success” Final Rule	All

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1 Executive Summary

The purpose of this document is to describe the policies for waivers of the Skilled Nursing Facility (SNF) 3-Day Rule under the Shared Savings Program and the Medicare ACO Track 1+ Model. Specifically, this document provides background on the SNF 3-Day Rule, waiver-eligibility criteria for ACOs and SNF affiliates, as well as information on how to apply for a SNF 3-Day Rule Waiver.

Under the Shared Savings Program, the Centers for Medicare & Medicaid Services (CMS) enters into a participation agreement with each participating Accountable Care Organization (ACO). CMS will reward eligible ACOs when they lower growth in Medicare Parts A and B fee-for-service (FFS) costs (relative to their ACO-specific benchmark) if, at the same time, they meet performance standards on quality of care.

The SNF 3-Day Rule Waiver waives the requirement for a 3-day inpatient hospital stay prior to a Medicare-covered, post-hospital, extended-care service for eligible beneficiaries (see [Section 4.2](#) below). Only Shared Savings Program ACOs that are currently participating in, or applying to, certain Shared Savings Program performance-based risk tracks have the opportunity to apply for a waiver of the SNF 3-Day Rule, and they must apply separately for the waiver during the annual application process as described in [Section 3.3](#) below.

To apply for a SNF 3-Day Rule Waiver, ACOs must:

- Meet specific eligibility criteria;
- Submit a SNF Affiliate List;
- Submit sample SNF Affiliate Agreement(s);
- Complete the SNF Affiliate Agreement table in the ACO Management System (ACOMS);
- Submit an executed SNF Affiliate Agreement for each proposed SNF affiliate; and
- Submit a communication plan, beneficiary evaluation and admission plan, and a care management plan.

2 Background

This document is subject to periodic change. Any substantive changes to this document are noted in the [revision history](#).

2.1 STATUTORY & REGULATORY BACKGROUND

An ACO is composed of groups of doctors, hospitals, and other health care providers that come together voluntarily to give coordinated, high-quality care to their Medicare FFS beneficiaries. The Shared Savings Program rewards ACOs that improve the quality and cost efficiency of health care. The authority for the Shared Savings Program is in

Section 1899 of the Social Security Act (the Act), which was added by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. CMS has published four final rules regulating the Shared Savings Program. The first final rule was published in November 2011, the second was published in June 2015, the third was published in June 2016, and the fourth was published in December 2018. Additionally, CMS has addressed certain issues related to the Shared Savings Program in the annual Physician Fee Schedule (PFS) rulemaking.

The June 2015 Final Rule established the requirements for waiving the SNF 3-day rule under the Shared Savings Program in 42 CFR § 425.612 of the Shared Savings Program regulations (80 FR 32800). Through the Calendar Year (CY) 2017 PFS Final Rule, CMS finalized additional beneficiary protections related to use of the SNF 3-Day Rule Waiver (81 FR 80510). In the CY 2018 PFS final rule, CMS made further changes to streamline the SNF 3-Day Rule Waiver application requirements by removing certain documentation requirements, with a goal of reducing burden for applicants.¹ In the December 2018 final rule, CMS expanded access to the program's existing SNF 3-Day Rule Waiver for ACOs under performance-based risk by allowing ACOs with preliminary prospective assignment, as well as allowing hospitals or CAHs under a swing bed agreement to be eligible to partner with ACOs as SNF affiliates. The complete Shared Savings Program regulations can be found in the Code of Federal Regulations at 42 CFR part 425. Additionally, the [Electronic Code of Federal Regulations website](#) is a useful resource for viewing the program regulations.

3 SNF 3-Day Rule Waiver Overview

The SNF 3-Day Rule Waiver waives the requirement for a 3-day inpatient hospital stay prior to a Medicare-covered, post-hospital, extended-care service for eligible beneficiaries (see [Section 4.2](#) below).

3.1 BACKGROUND ON THE SNF 3-DAY RULE

Section 1819(a) of the Act defines a SNF, in part, as an institution (or a distinct part of an institution) that is not primarily for the care and treatment of mental diseases but is primarily engaged in providing the following to residents:

- Skilled nursing care and related services for residents who require medical or nursing care.
- Skilled rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

The Medicare SNF benefit applies to beneficiaries who require a short-term intensive stay in a SNF and skilled nursing and/or skilled rehabilitation care. Pursuant to section 1861(i) of the Act, beneficiaries must have a prior inpatient hospital stay of no fewer

¹ Medicare Shared Savings Program: Accountable Care Organizations, 82 FR 53271 – 53222, 53371 (Nov. 15, 2017) (Amending 42 CFR § 425.612 by removing paragraphs (a)(1)(i)(A)(4) and (a)(1)(i)(C)).

than three consecutive days to be eligible for Medicare coverage of inpatient SNF care. This requirement is referred to as the SNF 3-Day Rule.

3.2 OVERVIEW OF THE SNF 3-DAY RULE WAIVER

Section 1899(f) of the Act permits the Secretary to waive certain payment or other program requirements as may be necessary to carry out the Shared Savings Program. To support ACOs' efforts to increase quality and decrease costs, CMS finalized a waiver of the SNF 3-Day Rule for eligible ACOs participating in certain performance-based risk initiatives of the Shared Savings Program (§ 425.612). Specifically, CMS has used the authority under section 1899(f) to waive section 1861(i) of the Act to allow coverage of certain SNF services that are not preceded by a qualifying 3-day inpatient hospital stay for eligible beneficiaries who are prospectively or preliminarily prospectively assigned to an ACO participating in Levels C, D, or E of the BASIC track, or the ENHANCED track (formerly known as Track 3) of the Shared Savings Program. Similarly, CMS has used the waiver authority under section 1115A(d)(1) of the Act to waive section 1861(i) of the Act for the Track 1+ Model, consistent with the SNF 3-Day Rule Waiver under 42 CFR § 425.612.

Eligible ACOs may apply for the use of a SNF 3-Day Rule Waiver during their agreement period or at the time of application to participate in the program. ACOs, including those applying for a waiver during the term of an existing participation agreement, must follow the annual application process as described in [Section 3.3](#) below. For PY 2019, SNF 3-Day Rule Waivers are effective beginning July 1 following approval of a SNF 3-Day Rule Waiver Application. Applications for a SNF 3-Day Rule Waiver in subsequent years will have an effective date of January 1 of the performance year following approval. Once approved, an ACO will maintain its SNF 3-Day Rule Waiver for the remainder of its current participation agreement, unless CMS determines it is necessary to revoke the ACO's waiver as provided in § 425.612(d)(3) or under the terms of the Track 1+ Model. If CMS or the ACO terminates the ACO's participation agreement, the waiver ends on the date specified by CMS in the termination notice or on the effective date of termination, as specified in the ACO's advance written notice to CMS required under § 425.220.

It is important to note that a SNF 3-Day Rule Waiver does not create a new benefit or extend Medicare SNF coverage to patients who could be treated in outpatient settings or who require long-term custodial care. The waiver is intended to provide ACOs that are participating in certain performance-based risk tracks with additional flexibility to increase quality and decrease costs. The SNF benefit itself remains unchanged. The SNF 3-Day Rule Waiver is only applicable for services furnished in SNFs that meet the eligibility requirements in § 425.612, discussed below in [Section 4](#).

The SNF 3-Day Rule Waiver does not restrict a beneficiary's choice of provider or supplier. A beneficiary continues to have the option to seek care from any Medicare FFS provider or supplier, including from a SNF or other facility that is not an affiliate of

an ACO that is participating in the Shared Savings Program. In such circumstances, normal Medicare requirements apply, including the requirement for a 3-day, inpatient hospitalization.

3.3 APPLYING FOR A SNF 3-DAY RULE WAIVER

Necessary steps to apply for a SNF 3-Day Rule Waiver include:

- Submit a Notice of Intent to Apply (NOIA) for a SNF 3-Day Rule Waiver.
- Submit a SNF 3-Day Rule Waiver Application.

ADDITIONAL RESOURCES

- [Application Toolkit webpage](#)
- [Application Types & Timeline webpage](#)

The SNF 3-Day Rule Waiver Application requires the ACO to provide sufficient information to demonstrate that the ACO has the capacity to identify and manage beneficiaries who, under the waiver, would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than 3 days.

Applicants must submit their applications through ACO-MS in accordance with the guidance provided on the [Application Toolkit webpage](#). The Shared Savings Program [Application Types & Timeline webpage](#) contains an up-to-date list of all applicable deadlines. Additionally, refer to this webpage to find the latest information concerning the Shared Savings Program application process.

During the application process, ACOs receive multiple request for information (RFI) notifications summarizing CMS' review of submitted application information. ACOs should carefully review the RFIs sent by CMS because they only have a few opportunities to correct deficiencies identified in the submitted application information. Please note that while the application cycle deadlines are subject to change, CMS will not accept late submissions.

4 SNF 3-Day Rule Waiver Eligibility

Beneficiaries, SNFs, and ACOs must meet the eligibility requirements specified in § 425.612 for Medicare to make payment for services provided pursuant to a SNF 3-Day Rule Waiver.

4.1 ACO ELIGIBILITY FOR THE SNF 3-DAY RULE WAIVER

To be eligible to apply for the SNF 3-Day Rule Waiver, an ACO must be applying to participate in the Medicare Shared Savings Program Levels C, D, or E of the BASIC track or the ENHANCED track. Additionally, existing Shared Savings Program ACOs currently in the ENHANCED track (formerly known as Track 3) or the Medicare ACO Track 1+ Model are eligible to apply. ACOs applying to Levels A and B (one-sided model) of the BASIC track are not eligible to apply for the SNF 3-Day Rule Waiver.

4.2 BENEFICIARY ELIGIBILITY FOR THE SNF 3-DAY RULE WAIVER

To be eligible to receive covered SNF services under the waiver, a beneficiary must appear on an eligible Assignment List Report:

- For an ACO that has selected preliminary prospective assignment with retrospective reconciliation, the beneficiary must appear on the list of preliminarily prospectively assigned beneficiaries at the beginning of the performance year or on the first, second, or third quarterly preliminary prospective assignment list for the performance year in which they are admitted to the eligible SNF (referred to as a SNF affiliate, described in [Section 5](#));
- For an ACO that has selected prospective assignment under § 425.400(a)(3), the beneficiary must be prospectively assigned to the ACO for the performance year in which he or she is admitted to the eligible SNF.

Additionally, beneficiaries must meet the following requirements:

- Not reside in a SNF or other long-term care setting;
- Be medically stable;
- Not require inpatient or further inpatient hospital evaluation or treatment;
- Have certain and confirmed diagnoses;
- Have an identified skilled nursing or rehabilitation need that he/she cannot receive as an outpatient; and
- Have been evaluated and approved for admission to the SNF within 3 days prior to the SNF admission by an ACO provider/supplier that is a physician, consistent with the ACO's beneficiary evaluation and admission plan.

As described in the December 2018 Final Rule, consistent with the approach taken under the Pioneer ACO Model and Next Generation ACO Model, CMS does not consider independent or assisted living facilities to be long-term care settings for purposes of determining a beneficiary's eligibility to receive SNF services pursuant to the SNF 3-Day Rule Waiver. Additionally, concerning the requirement that a beneficiary has been evaluated by an ACO provider/supplier that is a physician, this criterion does not preclude review and approval by an ACO provider/supplier that is a physician overseeing an evaluation conducted by another provider/supplier that is involved in the beneficiary's care. That provider can be a nurse practitioner, a physician assistant, or a clinical nurse specialist who has directly evaluated the beneficiary and has found that the beneficiary requires admission to a SNF.

Prospectively Assigned Beneficiaries

ACOs will receive a prospective assignment list from CMS at the start of each performance year. On a quarterly basis, ACOs under the prospective assignment methodology receive a list of beneficiaries whom CMS has removed from the ACO's prospective assignment list as a result of meeting select assignment exclusion criteria. To learn more about the assignment methodologies, refer to the current version of the Shared Savings and Losses and Assignment Methodology Specifications available on the [CMS website](#).

During the performance year, a beneficiary loses his or her eligibility to receive covered SNF services under the waiver if he or she appears on a quarterly report excluding the beneficiary from the ACO's original prospective assignment list, unless the 90-day grace period applies (refer to [Section 4.4](#) below). The beneficiaries who remain on the ACO's prospective assignment list continue to be eligible to receive covered SNF services under the applicable SNF 3-Day Rule Waiver. ACOs should notify their SNF affiliates of changes to beneficiary eligibility in a timely manner to comply with the waiver requirements. ACOs should refer to the Assignment List Report and Assignment Summary Report User's Guide, located on the [SSP ACO Portal](#), for more information on the prospective assignment lists and quarterly exclusion reports.

Preliminarily Prospectively Assigned Beneficiaries

ACOs will receive a preliminary prospective assignment list from CMS at the start of each performance year. On a quarterly basis, ACOs under the preliminary prospective with retrospective reconciliation assignment methodology receive a new list of beneficiaries whom CMS has preliminarily prospectively assigned to the ACO for the quarter. To learn more about the assignment methodologies, refer to the current version of the Shared Savings and Losses and Assignment Methodology Specifications available on the [CMS website](#).

The SNF 3-Day Rule Waiver is available for all beneficiaries who have been identified as preliminarily prospectively assigned to the ACO on the initial performance year assignment list or on one or more assignment lists for quarters 1, 2, and 3 of the performance year, for SNF services provided after the beneficiary first appeared on one of the assignment lists for the applicable performance year. The beneficiary remains eligible to receive SNF services furnished in accordance with the waiver unless he or she is no longer eligible for assignment to the ACO because he or she is no longer enrolled in both Part A and Part B or has enrolled in a Medicare group health plan.

4.3 SNF ELIGIBILITY FOR THE SNF 3-DAY RULE WAIVER

ACOs must provide CMS with a list of SNFs (referred to as SNF affiliates) with which the ACO will partner along with executed written SNF Affiliate Agreements between the ACO and each listed SNF affiliate (refer to [Section 5](#)). SNF affiliates that are eligible to be included in the CMS Five-Star Quality Rating System must have and maintain an

overall rating of three stars or higher. Beginning July 1, 2019, hospitals and CAHs operating under swing bed agreements are eligible to partner with ACOs as SNF affiliates. Hospitals and CAHs operating under swing bed agreements are not required to have or maintain a rating on the CMS Five-Star Quality Rating System. The SNFs included on the ACO's list (referred to as the "SNF Affiliate List") undergo a program integrity review and CMS reviews the SNF Affiliate Agreements for compliance with the SNF 3-Day Rule Waiver requirements in § 425.612. ACOs submit the SNF Affiliate List and the SNF Affiliate Agreements through ACO-MS.

4.4 BENEFICIARY PROTECTIONS AND 90-DAY GRACE PERIOD

CMS determined that additional protections were necessary for beneficiaries receiving services under a SNF 3-Day Rule Waiver and has included the following beneficiary protections.

90-day grace period

CMS modified § 425.612(a)(1) to include a 90-day grace period that will permit payment for SNF services provided without a qualifying inpatient stay to certain beneficiaries who were initially included on the ACO's prospective assignment list for a performance year but who were subsequently excluded during the performance year, if such services would otherwise be covered under the SNF 3-Day Rule Waiver. This allows SNF waiver-approved ACOs and SNF affiliates a grace period to update their systems to account for beneficiaries who were previously eligible to receive services under a SNF 3-Day Rule Waiver but were excluded from assignment to the ACO in the most recent quarterly update to the ACO's prospective assignment list. The 90-day grace period begins on the date that CMS delivers the quarterly beneficiary exclusion list to an ACO.

Beneficiaries who are preliminarily prospectively assigned to a waiver-approved ACO remain eligible to receive services furnished in accordance with the SNF 3-Day Rule Waiver for the remainder of that performance year unless they enroll in a Medicare group health plan or are otherwise no longer enrolled in Part A and Part B; therefore, these beneficiaries do not require a grace period.

ACOs should educate SNF affiliates and ACO providers/suppliers about the 90-day grace period. ACOs are expected to communicate information contained in the assignment list and quarterly exclusion reports in a timely and accurate manner to their SNF affiliates and ACO providers/suppliers that rely on this information during their evaluation of a beneficiary for admission under a SNF 3-Day Rule Waiver.

No payment to a SNF affiliate where the beneficiary is not prospectively assigned to the ACO and any 90-day grace period that has lapsed

In the event that a SNF affiliate of an ACO that has been approved for the SNF 3-Day Rule Waiver admits an FFS beneficiary who was never prospectively or preliminarily prospectively assigned to the ACO (or was prospectively assigned but was later excluded and the 90-day grace period has lapsed), and the claim is rejected only for lack of a qualifying inpatient hospital stay, CMS will make no payment to the SNF, and the SNF may not charge the beneficiary for the non-covered SNF services and must return to the beneficiary any monies collected for such services. In this circumstance, the SNF affiliate will be prohibited from charging a beneficiary for non-covered SNF services, even in cases where the beneficiary explicitly requested or agreed to being admitted to the SNF in the absence of a qualifying 3-day inpatient hospital stay, if all other requirements for coverage are met.

5 SNF Affiliate List

An ACO must notify CMS of changes to its SNF Affiliate List in the form and manner specified by CMS.

5.1 SNF AFFILIATE LIST REQUIREMENTS

The SNF Affiliate List must include the proposed SNF affiliate's legal business name (LBN), taxpayer identification number (TIN), CMS Certification Number (CCN), and CCN LBN for each SNF, and/or hospital or CAH operating under a swing bed agreement, that wishes to partner with the ACO for purposes of the SNF 3-Day Rule Waiver. Each proposed SNF affiliate must be Medicare-enrolled and have signed a valid SNF Affiliate Agreement with the ACO that meets the requirements in § 425.612. Additionally, for ACOs eligible to be included in the CMS Five-Star Quality Rating System, the SNF affiliate must have an overall quality rating of three or more stars. If a SNF, or hospital or CAH operating under a swing bed agreement, does not meet all of these requirements, CMS will reject the ACO's request to include the facility on its SNF Affiliate List.

ACOs are responsible for ensuring their SNF Affiliate Lists are accurate and include only eligible SNF affiliates that have executed valid SNF Affiliate Agreements to partner with the ACO. After CMS approves a SNF 3-Day Rule Waiver Application, the ACO:

- Must maintain, update, and annually provide the list of SNF affiliates to CMS using ACO-MS at the beginning of each performance year and at other times as specified by CMS;
- Must certify the accuracy of the SNF Affiliate List prior to the start of each performance year and at other times as specified by CMS; and

- May add or remove SNF affiliates during the term of the Shared Savings Program ACO Participation Agreement.²

SNF affiliates are not required to be ACO participants or ACO providers/suppliers. SNF affiliates may partner with more than one Shared Savings Program ACO. In addition, SNF affiliates that are not ACO participants or ACO providers/suppliers may partner with entities participating in other shared savings initiatives. Note that SNF affiliates that are ACO participants or ACO providers/suppliers do not automatically qualify to offer services under the applicable SNF 3-Day Rule Waiver. A SNF, or hospital or CAH operating under a swing bed agreement, must appear on the certified SNF Affiliate List and have entered the required SNF Affiliate Agreement with the ACO, as well as meet all other applicable requirements, in order to be eligible for payment for services provided under the SNF 3-Day Rule Waiver.

CMS encourages ACOs to validate the proposed SNF affiliate TINs and CCNs by submitting them through ACO-MS. To ensure the SNF 3-Day Rule Waiver is applied and claims are processed correctly, the correct TIN and CCN must appear in the Provider Enrollment, Chain, and Ownership System (PECOS) and CMS claims data. If a SNF, or hospital or CAH operating under a swing bed agreement, using a CCN that does not appear on the SNF Affiliate List admits a beneficiary without a qualifying 3-day inpatient stay, CMS will reject the claim.

CMS also encourages ACOs and SNF affiliates to discuss any changes to the SNF affiliates' TINs and/or CCNs that appear on the certified SNF Affiliate List. If a SNF affiliate's TIN and/or CCN changes (e.g., digits change) during a performance year, the ACO must report the changes to CMS through ACO-MS. Such changes will result in the SNF affiliate no longer being eligible to use the SNF 3-Day Rule Waiver, because an entity that changes its TIN and/or CCN is considered a new SNF affiliate. Any new SNF affiliate needs to be evaluated and approved by CMS before being eligible, in the upcoming performance year, to use a SNF 3-Day Rule Waiver. Any new SNF affiliate (TIN and/or CCN) is subject to the SNF Affiliate List review cycle described below.

5.1.1 SNF AFFILIATE LIST REVIEW CYCLE

ACOs already approved for a SNF 3-Day Rule Waiver may make changes, referred to as "change requests," to their SNF Affiliate Lists annually for the upcoming performance year during established review cycles. These review cycles coincide with the Shared Savings Program application review cycles. Allowable changes include adding, deleting, or modifying SNF affiliates on the SNF Affiliate List. These review cycles enable ACOs to receive CMS feedback and provide an opportunity for the ACO to correct any issues that may be identified in advance of the upcoming performance year.

² Any such changes will be reviewed during a CMS review cycle.

5.1.2 SNF AFFILIATE LIST CHANGE REQUEST PROCESS

ACOs can make changes by submitting change requests in ACO-MS. Change requests for the SNF Affiliate List must include accurate TINs, CCNs, and SNF Affiliate Agreements.

SNF Affiliate List Additions

During the performance year, an ACO that has been approved for a SNF 3-Day Rule Waiver that is in an agreement period and not yet eligible to request renewal may make changes to its SNF Affiliate List for the upcoming performance year. Change requests to add SNF affiliates for an upcoming performance year will be reviewed during an established CMS review cycle. These review cycles include the provision of CMS' feedback and the opportunity for an ACO to correct certain deficiencies CMS may find in advance of the upcoming performance year. Though an ACO may request an addition to its SNF Affiliate List during the change request review cycle for the upcoming performance year, there are deadlines for submitting change requests for consideration for the upcoming performance year.

It is important to note that any changes in a digit or digits of a required identifier (TIN or CCN) are considered to be a new request to add an entity to the SNF Affiliate List and are not permitted after the deadline. For example, if an ACO submits a change request to its SNF Affiliate List and a required identifier is submitted incorrectly (e.g., the digits of the TIN are typed incorrectly), the error can only be corrected by submitting a new change request. ACOs should ensure that all information submitted for SNF Affiliate List changes is correct.

SNF Affiliate List Deletions

When a SNF Affiliate Agreement terminates, the ACO must notify CMS within 30 days of the end of the agreement by deleting the SNF affiliate in ACO-MS. SNF waiver-approved ACOs may delete SNF affiliates from their SNF Affiliate List at any time during the performance year. Deletions are made directly in ACO-MS. When a SNF waiver-approved ACO terminates a SNF affiliate record, ACO-MS will prompt the ACO to enter the date on which it intends to terminate the SNF Affiliate Agreement. The SNF Affiliate Agreement end date entered by the ACO will be the date the SNF affiliate is no longer eligible for payment for services under the waiver. The ACO should alert the former SNF affiliate that as of the SNF Affiliate Agreement end date it will no longer be a SNF affiliate under the SNF 3-Day Rule Waiver. Once a SNF Affiliate Agreement is terminated, CMS will begin denying claims for lack of a 3-day inpatient stay that formerly would have been covered under the SNF 3-Day Rule Waiver.

5.2 SNF AFFILIATE LIST DATA VALIDATION TOOLS

ACOs can use the following tools to improve the quality of the SNF affiliate data provided to CMS.

5.2.1 VERIFYING MEDICARE ENROLLMENT

All SNFs included on an ACO's SNF Affiliate List must be Medicare-enrolled. CMS makes available a listing of all Medicare-enrolled providers/suppliers. Using the [Medicare Revalidation Lookup Tool](#), users can search for a provider/supplier by last name, first name, organization name, National Provider Identifier (NPI), or download a list of revalidation due dates. Providers/suppliers that are due for revalidation must display a revalidation due date; all other providers/suppliers that are not up for revalidation will display "TBD" (to be determined) in the due date field. The revalidation due date is posted up to 6 months in advance of the revalidation due date to provide sufficient notice and time for the provider/supplier to comply. For more information on provider/supplier revalidation, please visit the Medicare Revalidation webpage or have the provider/supplier contact its Medicare Administrative Contractor (MAC).

5.2.2 CMS FIVE-STAR QUALITY RATING SYSTEM

Each SNF affiliate eligible for inclusion in the [CMS Five-Star Quality Rating System](#) must maintain an overall rating of three stars or higher. ACOs should check their SNF affiliates' star rating on the Nursing Home Compare website before submitting their proposed SNF Affiliate Lists during the application period. CMS verifies that each proposed SNF affiliate has at least a three-star rating and will periodically check SNF affiliates' ratings during the agreement period. CMS recommends that ACOs integrate a periodic rating check into their compliance processes.

For ACOs currently approved for the SNF 3-Day Rule Waiver, CMS will periodically review each SNF affiliate's star rating. CMS will notify ACOs of SNF affiliates that have dropped below the required three-star rating. If a SNF affiliate does not have a star rating of three stars or higher at CMS' last check during the Annual Certification review cycle (see above), CMS will request that the ACO remove the SNF affiliate from the ACO's SNF Affiliate List for the upcoming performance year by entering a delete change request in ACO-MS. If the ACO does not remove the SNF affiliate for the upcoming performance year, CMS will remove the SNF affiliate.

6 SNF Affiliate Agreements

CMS requires that ACOs execute contractual agreements with each SNF affiliate to ensure that the ACO clearly articulates the requirements, and the SNF understands and agrees to comply with the requirements regarding the SNF 3-Day Rule Waiver. An ACO may not include a SNF on its SNF Affiliate List unless an individual authorized to bind the SNF affiliate's Medicare-enrolled TIN has signed a SNF Affiliate Agreement with the ACO. ACOs must submit sample SNF Affiliate Agreement(s) with their SNF 3-Day Rule Waiver Applications. The sample SNF Affiliate Agreement(s) must match each agreement that the ACO executes with a SNF affiliate and must comply with the SNF Affiliate Agreement requirements. CMS does not provide a "boilerplate" agreement for ACOs, but instead reviews each sample agreement to ensure that it meets all

requirements. If CMS identifies deficiencies with a sample agreement, the ACO must modify the sample agreement and re-execute the conforming agreements with each proposed SNF affiliate.

All ACOs that are eligible to apply or are currently approved for a SNF 3-Day Rule Waiver must submit their sample SNF Affiliate Agreements, complete the SNF Affiliate Agreement table, and submit all executed SNF Affiliate Agreements in ACO-MS. ACOs that are eligible to apply have the option to submit sample SNF Affiliate Agreement(s) with their NOIAs. CMS will review and provide feedback on sample agreements submitted with the NOIA. Although this step is optional, an ACO that submits a sample agreement(s) with its NOIA can save time and effort, because it may not have to revise and re-execute agreements later in the application process.

Regardless of when an ACO submits its sample agreements, it must complete the SNF Affiliate Agreement table in ACO-MS (see [Appendix A](#)) to identify where the agreement requirements for the applicable SNF 3-Day Rule Waiver are met. If an ACO chooses to submit a sample agreement with its NOIA, it must also complete the SNF Affiliate Agreement table in ACO-MS at that time.

6.1 SNF AFFILIATE AGREEMENT REQUIREMENTS

The SNF Affiliate Agreement with the ACO includes all SNF affiliates under the Medicare-enrolled TIN that agree to partner with the ACO for purposes of a SNF 3-Day Rule Waiver. While the TIN signs the SNF Affiliate Agreement on behalf of the SNF affiliates, the TIN should notify all providers and suppliers billing through each of the CCNs on the SNF Affiliate List of the SNF 3-Day Rule Waiver requirements of the Shared Savings Program and Track 1+ Model, as applicable, before the SNF affiliates begin to admit beneficiaries under a SNF 3-Day Rule Waiver. CMS will ask ACOs to revise and re-execute their SNF Affiliate Agreements if they are missing one or more of the required elements set forth in [Appendix A](#).

Other agreement requirements:

- Expressly state the only parties to the agreement are the ACO and the SNF affiliate.
- Signed on behalf of the ACO and the SNF affiliate by individuals who are authorized to bind the ACO and the SNF affiliate, respectively. The Medicare-enrolled TIN is authorized to bind the SNF affiliate CCN(s) billing under the TIN.
- The LBNs of the parties on the SNF Affiliate Agreement must match those provided in ACO-MS and on the SNF Affiliate List.
- On the signature page (see sample signature page below) of the sample SNF Affiliate Agreement, include a section to list the SNF affiliate CCN numbers and CCN LBNs under the Medicare-enrolled TIN, and in each executed SNF Affiliate Agreement, list the SNF affiliate's CCN number and CCN LBN for each SNF affiliate under the Medicare-enrolled TIN that agrees to be a SNF affiliate of the ACO. ACOs

should also include a statement that the Medicare-enrolled TIN agrees to the terms and conditions of the SNF Affiliate Agreement on behalf of the CCN of each listed SNF affiliate.

CMS strongly recommends ACOs include the following information in their sample SNF Affiliate Agreements and executed SNF Affiliate Agreements to ensure that each SNF affiliate understands how participating in a SNF 3-Day Rule Waiver may impact them. If this information is not included in the SNF Affiliate Agreement, ACOs should clearly discuss the following with each SNF affiliate during the ACO's SNF 3-Day Rule Waiver SNF affiliate education and onboarding process before an authorized representative of the SNF affiliate signs the SNF Affiliate Agreement:

- Training requirements on both the ACO's beneficiary evaluation and admission plan and the care management plan for beneficiaries admitted to the SNF affiliate pursuant to the waiver.
- Express requirement that the ACO is to notify the SNF affiliate when the SNF 3-Day Rule Waiver has ended.

6.2 EXECUTED SNF AFFILIATE AGREEMENT REQUIREMENTS

Each executed SNF Affiliate Agreement must match the approved sample SNF Affiliate Agreement and include a signature page signed by individuals who have the legal authority to bind the SNF affiliate or ACO. The person signing on behalf of the ACO must be listed in ACO-MS as either the ACO Executive or Authorized to Sign contact role. The signature page must reflect information (such as contact information) for both the ACO and the SNF affiliate and must be consistent with the ACO's legal entity name and SNF affiliate's LBN listed on the first page of the SNF Affiliate Agreement. The Shared Savings Program refers to the legal name of the ACO as the "legal entity name" and the legal name of a SNF affiliate as the "legal business name." The signature page must list the SNF affiliate's CCN and CCN LBN for each SNF affiliate under the Medicare-enrolled TIN that agrees to be a SNF affiliate of the ACO, and include a statement that the Medicare-enrolled TIN agrees to the terms and conditions of the SNF Affiliate Agreement on behalf of the CCN of each listed SNF affiliate.

CMS must receive a copy of each executed SNF Affiliate Agreement (first page and signature page) that includes either a digital signature ([Appendix C](#)) or a wet signature,³ and a signature date, from both the ACO and SNF affiliate. CMS strongly encourages ACOs to include the information indicated in the format referenced in [Appendix B](#).

Please note, ACOs that choose to include their communication plan, beneficiary evaluation and admission plan, and care management plan as appendices to their agreements, or that incorporate them by reference into their agreements, will be required to amend or update and re-execute their SNF Affiliate Agreements whenever

³ Wet signatures are handwritten signatures (i.e., not stamped).

any of these plans are revised to ensure that SNF affiliates are aware of all modifications to these important documents.

7 ACO and SNF Affiliate Communication Plan

As part of the application for a SNF 3-Day Rule Waiver, ACOs that are eligible to apply must provide a narrative detailing the communication plan between the ACO and its SNF affiliates. CMS requires ACOs to describe the following information in their communication plan narratives:

- The process that the ACO will use to evaluate and periodically update its communication plan with its SNF affiliates.
- The process that the ACO will use to identify and designate the person(s) at the ACO with whom SNF affiliates will communicate and coordinate admissions.
- The process that each SNF affiliate will use to identify and designate the person(s) at the SNF affiliate with whom the ACO will communicate and coordinate admissions, including monitoring SNF length of stay.
- The process ACOs and SNFs will use to share information across sites of care and make it available to all members of the care team for optimal care integration. This includes identification of Health Insurance Portability and Accountability Act (HIPAA)-compliant communication tools that the care team will use to ensure that the designated person(s) at the ACO is aware of admissions to SNF affiliates pursuant to a waiver and appropriately involved in the clinical management of these beneficiaries, including a plan for communicating necessary information when key contacts are not available.
- How frequently communications occur between the ACO and its SNF affiliates.
- The process the ACO will use to communicate the beneficiary evaluation and admission plan and the care management plan to the SNF affiliates and other individuals or entities responsible for or involved in providing or coordinating SNF services furnished under a waiver.
- The process the ACO will use to respond to questions and complaints related to the ACO's use of the SNF 3-Day Rule Waiver from SNF affiliates, ACO participants, ACO providers/suppliers, beneficiaries, acute care hospitals, and other stakeholders.

CMS recommends ACOs include a process for timely sharing of the preliminary prospective and prospective beneficiary assignment list, as well as the quarterly exclusion lists for prospectively assigned beneficiaries, with SNF affiliates so that ACOs and SNF affiliates can identify correctly the beneficiaries eligible to receive covered SNF services under the SNF 3-Day Rule Waiver.

8 SNF 3-Day Rule Waiver Medicare Claims Processing

SNF waiver-approved ACOs must comply with all Medicare claims submission requirements, except the requirement for a 3-day inpatient hospital stay prior to a Medicare-covered, post-hospital, extended care service (42 CFR § 425.612(a)). A SNF 3-Day Rule Waiver does not change FFS billing requirements (other than the 3-day inpatient stay requirement).

SNFs do not include any new data elements when submitting FFS claims to indicate their intent to use a SNF 3-Day Rule Waiver. For institutional claims, CMS will set the Demonstration Number field to “77” for claims that meet all of the following conditions:

- “Received” date on the claim is on or after January 1 of the calendar year indicated on the claim’s “From” date;
- A CCN (first 6 digits) is found on the claim that is also found on the ACO’s certified SNF Affiliate List;
- Beneficiary Health Insurance Claim Number (HICN) found on the claim which is also found on the ACO’s assignment list;
- The date of service “From” date on the claim is on or after the effective start date of a waiver; and
- The ACO ID (AXXXX) associated with the SNF affiliate is the same as the ACO ID associated with the eligible beneficiary.

If a SNF claim is rejected exclusively due to a lack of a qualifying hospital stay, meaning all other Medicare FFS coverage, claims processing, and other applicable requirements are met, the SNF should verify that the ACO, SNF, and beneficiary meet waiver eligibility requirements under § 425.612, described above. If the ACO, SNF, and beneficiary meet these eligibility requirements, the SNF should contact its MAC to inquire about payment for the claim pursuant to the terms of the SNF 3-Day Rule Waiver under the Shared Savings Program.

Note that beneficiaries maintain their freedom of choice to select any SNF they choose. If a beneficiary selects a SNF that is not on an ACO’s certified SNF Affiliate List and that SNF admits the beneficiary without a qualifying hospital stay, CMS will reject the claim for failing to meet one of the required elements (SNF must be a SNF affiliate on the approved SNF Affiliate List). If the selected SNF is not a SNF affiliate, current Medicare SNF coverage requirements apply for SNF services. CMS only reimburses the SNF for services furnished to beneficiaries without a prior 3-day inpatient stay if the SNF is on the ACO’s SNF Affiliate List for the performance year in which it admits the beneficiary, and all other criteria for eligibility under the SNF 3-Day Rule Waiver are satisfied. If CMS rejects a SNF claim for lack of a 3-day inpatient hospital stay and the ACO, SNF affiliate, and/or the beneficiary did not meet the eligibility requirements (described in

[Section 4](#) above), CMS may require the SNF waiver-approved ACO to submit a corrective action plan (CAP) addressing what actions the ACO will take to ensure appropriate use of the waiver in the future and take other remedial actions, as appropriate.

9 SNF 3-Day Rule Waiver Beneficiary Communications

For SNF waiver-approved ACOs, it is important to highlight that CMS has certain rules and policies governing communications to beneficiaries. Of note, hospital discharge planning conditions of participation standards found at §§ 482.13 and 482.43(c)(6)–(8) continue to apply. In part, these rules require hospitals to include a list of Medicare-participating SNFs in the discharge plan for those patients for whom the plan indicates post-hospital extended care services are required. During the discharge planning process, the hospital must inform the patient of his/her freedom to choose from among Medicare-participating, post-hospital providers and must not direct the patient to specific provider(s) or otherwise limit the pool of qualified providers from which the patient may choose. Additionally, under the Patient's Rights Condition of Participation at § 482.13, the hospital must always respect the patient's right to make informed decisions.

CMS has developed a SNF 3-Day Rule Waiver Notice template for SNF waiver-approved ACOs to use to describe the waiver to the eligible beneficiaries. For example, a participating physician can use the waiver notice to supplement the discharge planning conversation and aid eligible beneficiaries in making an informed decision about whether and where to receive SNF services. The latest version of this template is included in the ACO Marketing Toolkit that is updated annually. ACOs are not permitted to modify template content, except in the spaces that CMS provides for ACO-specific information.

Please note that only SNF waiver-approved ACOs have the option to use the waiver notice template to educate their assigned beneficiaries who may be eligible to receive covered services under a SNF 3-Day Rule Waiver about the waiver. This notice is not intended as general information and could lead to confusion if shared with Medicare beneficiaries who are not eligible for such services.

10 SNF 3-Day Rule Waiver Public Reporting Requirements

Consistent with the requirements of § 425.612(d)(1), SNF waiver-approved ACOs must report their use of a SNF 3-Day Rule Waiver (reporting “yes” or “no”) as part of Shared Savings Program public reporting requirements.

11 SNF 3-Day Rule Waiver Compliance

CMS monitors and may audit the use of SNF 3-Day Rule Waivers. Misuse of a SNF 3-Day Rule Waiver may result in CMS taking remedial action against the ACO up to and including termination of the ACO from the Shared Savings Program. This would include, if applicable, termination from the Track 1+ Model. Additionally, CMS reserves the right to periodically review claims data, beneficiary medical records, and/or Minimum Data Set Nursing Home Assessments to confirm whether the ACO and its SNF affiliates appropriately confirm beneficiary eligibility prior to admission to a SNF. CMS may take remedial action if it finds that Medicare beneficiaries admitted to a SNF affiliate under the SNF 3-Day Rule Waiver did not meet beneficiary eligibility requirements.

Appendix A: Sample SNF Affiliate Agreement Table

ACOs must identify where the following requirements are in their sample agreements when submitting for CMS review. ACO-MS will display a table similar to the one below that the ACO can use to identify the location of each requirement.

a) The agreement must expressly require that the SNF affiliate agrees to the requirements and conditions of the Shared Savings Program (42 CFR Part 425) and SNF 3-Day Rule Waiver, including but not limited to, those specified in the participation agreement with CMS. § 425.612(a)(1)(iii)(B)(1). For ACOs participating in the Medicare ACO Track 1+ Model, the agreement must also expressly require that the SNF affiliate agrees to the requirements and conditions of the Track 1+ Model Participation Agreement.	
Agreement Section	Page Number
b) Effective dates of the SNF Affiliate Agreement. § 425.612(a)(1)(iii)(B)(2)	
Agreement Section	Page Number
c) The agreement must expressly require the SNF affiliate to implement and comply with the ACO's beneficiary evaluation and admission plan and the care management plan. § 425.612(a)(1)(iii)(B)(3)	
Agreement Section	Page Number
d) The agreement must expressly require the SNF affiliate to validate the eligibility of a beneficiary to receive covered SNF services in accordance with the waiver prior to admission. § 425.612(a)(1)(iii)(B)(4)	
Agreement Section	Page Number
e) The agreement must include the remedial processes and penalties that may apply for noncompliance. § 425.612(a)(1)(iii)(B)(5)	
Agreement Section	Page Number

Appendix B: Sample SNF Affiliate Agreement Introductory Paragraph and Signature Page

This ACO SNF Affiliate Agreement (“Agreement”) is by and between Accountable Care Organization of ABC, LLC DBA ABC ACO (“ACO”), and XYZ Group Practice P.C. (“SNF Affiliate”) and is effective [Month, Day, Year] (“Effective Date”).

< Body of Agreement >

Sample Signature Page:

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by the duly authorized representatives as of the dates below.

<u>For the ACO</u>	<u>For the SNF Affiliate</u>
_____ Legal Entity Name	_____ Legal Business Name
_____ DBA Name	_____ DBA Name
_____ Signature (on behalf of the ACO)	_____ Signature (on behalf of the SNF Affiliate)
_____ Name	_____ Name
_____ Title	_____ Title
_____ Date	_____ Date
_____ Address	_____ Address
_____ City, State ZIP Code	_____ City, State ZIP Code
_____ Business Phone	_____ Business Phone

Individual signing for the SNF affiliate(s) agrees to the terms and conditions of this Agreement on behalf of the following SNF affiliate CCNs:

< List of each CCN and CCN legal business name >

Appendix C: Information on Digital Signature Requirements

General Overview of Digital Signatures

If an ACO and SNF affiliate both consent to the use of digital signatures to execute a SNF Affiliate Agreement, they must use industry-accepted software to verify that the digital signatures represent the signers' consent to the terms of the agreement. Generally, a digital signature requires two components: the signature generation process (i.e., when a signer embeds a unique signature in the electronic document, thus legally executing the document), and the signature verification process (i.e., the mechanism by which an auditing party is able to verify the signature's authenticity).

ACOs should maintain all physical and/or electronic records necessary to verify each digital signature that they submit for CMS review and provide these records to the Shared Savings Program upon request.

Digital Signature Programs

The Shared Savings Program does not require the use of any particular software product to execute a SNF Affiliate Agreement, and any software that employs digital signature algorithms and that fulfills the two requirements—signature generation and signature verification—may be employed. Should CMS question the integrity of the software used, it may send the ACO a request for information (RFI). Should an ACO receive an RFI, it should provide CMS with documented evidence of the verification process for the signature in question.

Regulation of Digital Signatures

The [Electronic Signatures in Global and National Commerce Act \(E-Sign Act\)](#), which was enacted on June 30, 2000, promotes the use of electronic contract formation, signatures, and recordkeeping in private commerce by establishing legal equivalence between paper and electronic contracts; pen and ink signatures and electronic signatures; and other legally required written documents (termed “records”) and their electronic equivalents.

Additional Questions

What is the difference between a digital signature and an electronic signature?

Per Section 106 of the E-Sign Act, an electronic signature is defined as “an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record.” A digital signature consists of both the electronic signature itself and the verification process used to authenticate it. Digital signatures require the signer to use a digital certificate that links the signer with the document being signed, and a unique digital “fingerprint” is embedded in the document once signed. An electronic signature that lacks an

authentication verification process will not be accepted. Any non-handwritten signature must be verifiable according to industry standards.

Do both parties to the Agreement have to use digital signatures to sign the SNF Affiliate Agreement?

No. So long as both parties agree that a digital signature has the full force and effect of a handwritten signature, one party may use a digital signature while the other uses a handwritten signature.

However, if only one party will be executing the document by a handwritten signature, then that party must sign the document first. The remaining party should then scan in the signed document and embed their digital signature upon that scanned document. Printing out a document that contains a digital signature hinders validation of the encryption required for authentication in this format.

What if a party needs to amend or change an agreement that was executed with digital signatures?

Should an agreement containing a digital signature need to be amended, it must be re-executed with a new digital signature to indicate consent to the changes.

Can CMS recommend any digital signature programs for ACOs to use in executing agreements with SNF affiliates?

The E-Sign Act does not permit agencies to require the use of specific products and/or manufacturers. Therefore, CMS cannot recommend any specific products or companies. However, in choosing a digital signature program, an ACO should review the E-Sign Act requirements and focus on the particular product's signature generation and verification capabilities.

EXHIBIT X

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this certificate of need - supplemental materials and its exhibits and tables are true and correct to the best of my knowledge, information, and belief.

A handwritten signature in blue ink, appearing to read "Alison G. Brown", written over a horizontal line.

Signature

The name "Alison G. Brown" written in blue ink, appearing to be a printed or typed name, written over a horizontal line.


Printed Name

The title "President, UMMC Midtown Campus" written in blue ink, appearing to be a printed or typed name, written over a horizontal line.

Printed Title

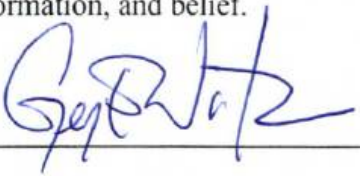
AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Certificate of Need Application and its exhibits and tables are true and correct to the best of my knowledge, information, and belief.


Signature
Name/Title

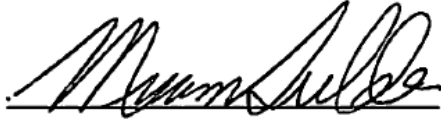
AFFIRMATION

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



AFFIRMATION

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

A handwritten signature in black ink, appearing to read "M. M. L. B.", is written over a horizontal line.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this letter dated May 23, 2016 to MHCC and its attachments are true and correct to the best of my knowledge, information, and belief.



Signature

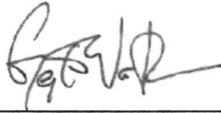
George Watson

Printed Name

Printed Title

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this letter dated August 17, 2016 to Ben Steffen, Executive Director, Maryland Health Care Commission, and its attachments are true and correct to the best of my knowledge, information, and belief.



Signature

George E. Watson

Printed Name

Printed Title