BAKER DONELSON

100 LIGHT STREET · BALTIMORE, MARYLAND 21202 · 410.685.1120 · bakerdonelson.com

HOWARD L. SOLLINS, SENIOR COUNSEL
Direct Dial: 410-862-1101
Direct Fax: 443-263-7569
E-Mail Address: hsollins@bakerdonelson.com

June 5, 2025

VIA HAND DELIVERY
AND E-MAIL TO MHCC.CONFILINGS@MARYLAND.GOV

Ewurama Shaw-Taylor, Ph.D., Chief
Certificate of Need
Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Columbia Vantage House Corp., dba Residences at Vantage Point
Certificate Of Need Application

Dear Dr. Shaw-Taylor:

Enclosed please find four copies of a Certificate of Need Application being filed on behalf of Columbia Vantage House Corp., dba Residences at Vantage Point ("RVP") regarding its request to serve the general public in 13 of its current 44 comprehensive care facility beds in Howard County. A full copy of the application will also be emailed to you in searchable PDF, Word and Excel forms as appropriate.

I hereby certify that a copy of the CON application has been sent to the affected local health department.

If any further information is needed, please let us know.

Sincerely,

Howard L. Sollins

HLS/tjr
Enclosures

cc: Pierce Carey, Executive Director
Residences at Vantage Point
Kevin McDonald, Consultant
Wynee Hawk, MHCC;
Jeanne-Marie Gawel, MHCC
Deanna Dunn, MHCC
Maura Rossman, MD,
Health Officer Howard County Health Department
John J. Eller, Esquire

RESIDENCES AT VANTAGE POINT

CERTIFICATE OF NEED APPLICATION FOR

COMPREHENSIVE CARE FACILITY BEDS

Columbia Vantage House Corp., dba

Residences at Vantage Point

June 5, 2025

Table of Contents

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Residences at Vantage Point**

Address 1: **5400 Vantage Point Rd.** Address 2

Columbia	**21044**	**Howard**
City	Zip	County

Provide complete ownership information that includes owners of the real property and improvements, bed rights, and operations. Include and identify the management company or companies, if applicable.* Identify the relationship between these entities. **Provide a chart showing the breakdown of ownership among all the entities.**

Detail concerning ownership, real estate, bed rights, and management is addressed below.

2. OWNERSHIP

The Corporation (Columbia Vantage House Corp., dba Residences at Vantage Point) is a nonstock corporation organized and operated for charitable and educational purposes, and not for pecuniary profit or financial gain. The corporation is governed by a volunteer board of directors who have no ownership stake in the organization.

3. APPLICANT. If the application has a coapplicant, provide the following information in an attachment.

Legal Name of Project Applicant:

Address 1: Address 2

City Zip County

Telephone:

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

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

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

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

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

A. Lead or Primary Contact

Name and Title:	**Pierce Carey, Executive Director**		
Company Name	**Columbia Vantage House Corp., dba Residences at Vantage Point**		
Address 1:	**5400 Vantage Point Rd.**	Address 2:	
	Columbia	**21044**	**Howard**
	City	Zip	County
Telephone:	**410-992-1101**		
E-mail Address (required):	**careyp@vantagepointresidences.org,**	Fax:	

If the company name is different than the applicant, briefly describe the relationship.

B. Additional or Alternate Contact

Name and Title: **Howard Sollins, Senior Counsel,**

Company Name: **Baker, Donelson, Bearman, Caldwell & Berkowitz, PC**

Address 1: **100 Light Street, 19th Floor** Address 2:

Baltimore, MD	**21202**	**Baltimore City**
City	Zip	County

Telephone: **410.862.1101** E-mail Address (required): **hsollins@bakerdonelson.com**

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

Legal Name of the Owner of the Real Property : **Vantage House, LLC**

Address: **5400 Vantage Point Rd.**

Columbia	**21044**	**Howard**	**Columbia**
City	Zip	State	County

Telephone:

8. NAME OF THE OWNER OF THE BED RIGHTS
(i.e., the person/entity that could sell the beds included in this application to a third party):

Legal Name of the Owner of the Rights to Sell the Nursing Home Beds:

Columbia Vantage House Corp., dba Residences at Vantage Point

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

Address:

City	Zip	State	County

Telephone:

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

Name of Management Company: **Life Care Services LLC ("LCS")**

Address: **400 Locust Street Suite 820**

Des Moines	**50309**	**IA**	**Polk**
City	Zip	State	County

Telephone: **515-875-4500**

10. TYPE OF PROJECT

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

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

1. A new health care facility built, developed, or established ☐
2. An existing health care facility moved to another site. ☐
3. **A change in the bed capacity of a health care facility** ☒
4. **A change in the type or scope of any health care service offered by a health care facility** ☐

11. PROJECT DESCRIPTION

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

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

Applicant Introduction and Project Description

The Residences at Vantage Point ("RVP") is a Continuing Care Retirement Community ("CCRC") in Columbia, MD. New residents can select either an "all-inclusive" LifeCare residency agreement plan or a Fee-for-Service Plan. Columbia Vantage House Corp., dba Residences at Vantage Point leases the real property for $1 a year from a related entity Vantage House, LLC.

Established in 1990 as "Vantage House," RVP today consists of 201 independent apartments, 50 assisted living apartments, 24 of which are dedicated to memory support apartments, and 44 comprehensive nursing care beds. The currently-licensed 44 beds are located in sixteen (16) private and (14) semi-private rooms.

These 44 nursing home beds are restricted to use by its CCRC residents. RVP seeks approval to convert 13 of those nursing home beds into "public beds," making them available to the general public, thus filling the most recent need projection for Howard County promulgated by the Maryland Health Care Commission in its most recent Bed Need Projections for Comprehensive Care Beds, Target Year 2022.

While helping to fill community need – especially for Medicaid beneficiaries – the project will also contribute to the ongoing financial

health of this important community resource.

The "project" addressed in this application involves no new construction or renovation, but simply seeks approval to convert 13 beds to becoming available for public use. The only costs associated with the project are legal and consulting fees associated with preparing the application.

B. Comprehensive Project Description: The description should include details regarding:
   (1) Construction, renovation, and demolition plans
   (2) Changes in square footage of departments and units
   (3) Physical plant or location changes
   (4) Changes to affected services following completion of the project

The project would make 13 CCF beds available to the public that are currently restricted to CCRC residents, thus fulfilling the Howard County need as defined by the Maryland Health Care Commission.

12. **COMPLETE Table A** of the CON Table Package for Nursing Home Applications

13. Identify any **COMMUNITY-BASED SERVICES** that are or will be offered at the facility and explain how each one will be affected by the project.

RVP works with home health and hospice providers to meet the needs of its residents. See discussion at CON Standard 3, Community-based services.

14. **REQUIRED APPROVALS AND SITE CONTROL**

A. Site size: _____ acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan for the project as proposed been obtained?

Not Applicable – existing facility and consistent with current use.__

NO _____
(If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

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

(1) Owned by: _____

(2) Options to purchase held by: _____
Provide a copy of the purchase option as an attachment.

(3) Land Lease held by: **Columbia Vantage House Corp., dba Residences at Vantage Point (Exhibit 1).**
Provide a copy of the land lease as an attachment.

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

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

15. PROJECT IMPLEMENTATION SCHEDULE (COMAR 10.24.01.12A)

Not applicable, as the facility is fully in operation. Admission of "public patients" would commence as soon as the project is approved and Medicaid certification is effective.

.

16. PROJECT DRAWINGS

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

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

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

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

C. Specify dimensions and square footage of patient rooms.

See EXHIBIT 2: FACILITY DRAWINGS

17. FEATURES OF PROJECT CONSTRUCTION

Not Applicable. There is no construction or renovation associated with the project.

PART II - PROJECT BUDGET

Complete the Project Budget worksheet in the CON Table Package (Table C). (Exhibit 7).

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

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

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

The Corporation (Columbia Vantage House Corp., dba Residences at Vantage Point) is a nonstock corporation organized and operated for charitable and educational purposes, and not for pecuniary profit or financial gain. The corporation is Governed by a volunteer board of directors who have no ownership stake in the organization. The individuals responsible to implement the project are Executive Director Pierce Carey and Administrator Alexis Hitchcock.

2. Are all persons listed in response to Part 1, Questions 2, 3, 4, 7, 8, and 9 now involved or have ever been involved in the ownership, development, or management of another health care facility? If yes, provide a list of these facilities, including facility name, address, and dates of involvement.

EXHIBIT 3 lists the other health care facilities that Life Care Services, LLC is now involved with.

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

NO

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

related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

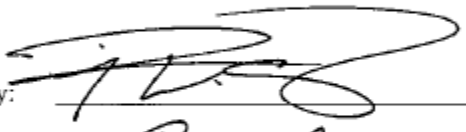
NO

5. Have the applicant, owners, or responsible individuals listed in response to Part 1, Questions 2, 3, 4, 7, 8, and 9 ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable to the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

NO

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility. (Exhibit 4).

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

By: 

Printed Name: Pierce Covey

Title: Executive Director

Date: May 29, 2025

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

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 10.24.01.08G(3), listed below.

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

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

10.24.20.05 Nursing Home Standards.

General Standards.

The Commission will use the following standards for the CON review of all nursing home projects.

(1) Bed Need and Average Annual Occupancy.

(a) For a relocation of existing nursing home beds currently in the inventory, an applicant shall demonstrate the need for the beds at the new site in the same jurisdiction. This demonstration may include, but is not limited to, a demonstration of unmet needs by a particular demographic, high utilization of nursing home beds in the jurisdiction during the past five years, and the ways in which the relocation will improve access to needed services or improve the quality of nursing home services.

(b) An applicant proposing a project that will not add nursing home beds to a jurisdiction but will add beds to an existing facility by relocation of existing licensed or temporarily delicensed nursing home beds within a jurisdiction, shall demonstrate that the facility being expanded operated all of its licensed beds at an occupancy rate of 80 percent or higher during the last two fiscal years.[1]

[1] KFF, accessed April 29, 2024, "Certified Nursing Facility Occupancy" https://www.kff.org/other/stateindicator/nursing-facility-occupancyrates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

(c) An applicant shall only propose a project in a jurisdiction that has an identified need for additional nursing home beds and the proposed increase in beds does not exceed the identified need for additional beds unless:

(i) More than fifty percent of the nursing homes in the jurisdiction had an average[2] overall Centers for Medicare & Medicaid Services (CMS) star rating of less than three stars in CMS's most recent five quarterly refreshes for which CMS data is reported; and

(ii) The applicant meets the quality requirement at COMAR 10.24.20.01A(1)(d).

(d) An applicant shall only propose a project under §(1)(c) of this regulation if:

(i) The applicant is an existing nursing home in the jurisdiction that is proposing expansion of its bed capacity and had an average overall CMS star rating of at least three stars in the most recent five quarterly refreshes for which CMS data are reported; or

(ii) The applicant proposing a new nursing home in the jurisdiction can document that all of the nursing homes it or any related entity operates had an average overall CMS star rating of at least three stars in the most recent five quarterly refreshes for which CMS data is reported.

(e) The Commission may consider an application by an existing freestanding nursing home with fewer than 100 beds that proposes a replacement facility with an appropriate expansion of bed capacity in a jurisdiction without identified need for additional beds if the applicant demonstrates that:

(i) Replacement of its physical plant is warranted, given the facility's age and condition; and

(ii) The additional bed capacity proposed is needed to make the replacement facility financially feasible and viable.

Applicant Response:

Part a) does not apply, as the proposed project is not a relocation of beds currently in the bed inventory. Part b) is also not applicable to the proposed project, which will add 13 beds to the existing inventory by converting 13 CCRC-restricted beds into publicly available beds, and does not involve a relocation of beds from another facility.

[2] An applicant may interpret average to be mean or median.

Parts c) and d) do not apply, as MHCC's projection shows a need for the requested 13 beds. Part e) does not apply, as this is not an application to replace an existing facility.

Speaking to this standard wholistically, the applicant submits that the proposed project is consistent with the State Health Plan projections which show a need for 13 additional beds in Howard County (**Exhibit 5: MHCC BED NEED PROJECTIONS FOR NURSING HOME BEDS, TARGET YEAR 2022).** That projected need is also supported by a number of factors that we will elaborate on in the NEED criterion later in this application.

Besides MHCC's latest need projection showing a need for 13 beds, those factors include:

- The target population in Howard County is growing at a rate that well exceeds the statewide rate, while…
- The per capita supply of nursing home beds relative to the target population is among the lowest (23rd out of 24 jurisdictions) in the state;
- Howard County Nursing homes deliver a higher percentage of their patient days to patients paid for by the Medicaid program than most of the state's other jurisdictions; and
- The occupancy rates for Howard County nursing homes have been consistently among the stronger of Maryland's 23 jurisdictions across the last decade.

The proposed project would add 13 beds to the existing inventory by converting 13 CCRC-restricted beds into publicly available beds, thus filling that projected need.
.
The project will also improve the general public's access to a facility that has consistently rated as a five-star facility, and make that facility available to the segment of the population reliant upon Medicaid.

(2) Medicaid Participation.

(a) The Commission may approve a Certificate of Need for a nursing home only for an applicant that participates or proposes to participate in the Medicaid program.

(b) Each applicant shall agree to serve and maintain a proportion of Medicaid days that is at least equal to the proportion of Medicaid days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus the 25th percentile value across all jurisdictions for each year based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission, as published in the *Maryland Register*. Additional information is available on the MHCC website.[3] This

[3] See the following link regarding the calculation: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_ltc/documents/chcf_ltc_nh_required_md_medical_assistance_participation_fy2020.pdf

requirement shall be a condition on any CON issued by the Commission.

(c) An applicant for new nursing home beds has three years during which to achieve the applicable proportion of Medicaid participation from the time the facility is licensed and shall show a good faith effort and reasonable progress toward achieving this goal in the first two years of its operation.

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

(e) Prior to licensure, an applicant shall provide an attestation of its intent to participate in the Medicaid program of the Maryland Department of Health to:

(i) Achieve and maintain the level of Medicaid participation required by

(ii) COMAR 10.24.20.05A(2)(b); and

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

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

APPLICANT RESPONSE:

As a CCRC-restricted nursing home RVP has not participated in the Medicaid program beyond serving its CCRC residents who are Medicaid beneficiaries. Going forward, if this bed conversion project is approved, RVP:

- Hereby attests to its intent to participate with the Medicaid program of the Maryland Department of Health (see letter addressed to Ms. Wynee Hawk, **Exhibit 6: LETTER OF INTENT, MEDICAID ELIGIBILITY).**
- Will gradually attain its required minimum target for Medicaid patient days in the 13 public beds within no more than three years of project approval. Based on the most recent Required Participation Rates for Nursing Homes by Region and Jurisdiction that requirement is 48.9% for the Central Maryland region. RVP will show substantial progress each year (see Tables F and G in the application Tables Package, Exhibit 7);
- RVP will maintain our Medicaid targets in the public beds through a structured daily census monitoring process. Our admissions and finance teams conduct a daily census analysis that tracks occupancy levels, payer sources, and upcoming transitions. This information is reviewed during daily stand-up meetings to ensure alignment with Medicaid targets and identify any variances. Additionally, we utilize an

electronic health record (EHR) system to generate real-time reports that highlight census trends and payer mix. Any discrepancies or potential gaps in meeting targets are promptly addressed through coordinated outreach and referral efforts to maintain compliance with Medicaid goals.

- Has developed a written policy **(Exhibit 8: ADMISSION CRITERIA)** requiring it to admit residents to the public beds whose primary source of payment on admission is Medicaid, and to meet the designated minimum level of Medicaid participation as defined by MHCC's *Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction* through incremental progress over no more than a three year period, and to continue to admit Medicaid residents to maintain its required level of participation once it has been attained.

(3) Community-Based Services.

An applicant shall demonstrate in writing its commitment to alternative community-based services and to minimizing the nursing home length of stay as appropriate for each resident and agree to:

(a) Provide information to every prospective resident about the existence of alternative community-based services, including Medicaid home and community-based waiver programs, Money Follows the Person Program, and other initiatives to promote care in the most appropriate settings;

Applicant Response:

Residences at Vantage Point maintains strong partnerships with local healthcare agencies and providers such as the Coalition of Geriatric Services, LifeSpan Network, LeadingAge Maryland, the Howard County Alzheimer's Association, and the Howard County Parkinson's Foundation, among others.

The facility maintains strong relationships with Gilchrist Hospice, and partnerships with home health agencies such as Bayada Home Health Care and BrightStar Care, thus enabling RVP to guide clients to the level of provider that best meets their particular needs. We are committed to utilizing the **Money Follows the Person Program** and have long-standing relationships with community-based organizations to provide clients with a full array of long term care options as well as seamless transitions to and from comprehensive care.

Attached as **Exhibit 9** please find letters from several of these health care community partners referencing these relationships.

Samples of materials given to prospective admissions describing alternative community-based services, attached as **Exhibit 10: SAMPLES OF MATERIALS GIVEN TO PROSPECTIVE ADMISSIONS DESCRIBING ALTERNATIVE COMMUNITY-BASED SERVICES.**

(b) Use Section Q of Minimum Data Set (MDS) 3.0 to assess the individual's interest in and willingness to pursue community-based alternatives;

Applicant Response:
The Applicant uses Section Q of the MDS 3.0 to assess individual interest in and willingness to pursue community-based alternatives. Per the Applicant's MDS Policy, "A registered nurse (RN) shall be responsible for conducting and coordinating the development and completion of the resident assessment (MDS)."

That policy states:

Policy Interpretation and Implementation

A registered nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (MDS).

The resident assessment coordinator must date and sign each assessment (MDS) to certify that the assessment has been completed.

Each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by:

a. dating and signing the assessment (MDS); and
b. identifying each section completed.

Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action and such incident must be promptly reported to the administrator.

A copy of this and related MDS policies is attached as **Exhibit 11**.

(c) Develop a discharge plan on admission with resident reassessment and plan validation at six-month intervals for the first 24 months. This plan is to be provided to the resident and/or designated representative; and

Applicant Response:
Residences at Vantage Point (RVP) initiates discharge planning upon admission to the nursing home for all Continuing Care Retirement Community (CCRC) residents and will continue to implement a 24-month plan with six-month intervals for non-CCRC public patients. In accordance with the Applicant's Policy, discharge planning remains a top priority for the facility.

Residents, or the facility on their behalf, may initiate a transfer to another skilled nursing facility or discharge to a home health agency, long-term care hospital, or inpatient rehabilitation facility. RVP assists residents in selecting a post-acute care provider that aligns with their goals of care and treatment preferences. The selection process is guided by:

- Standardized patient assessment data

- Quality measure data
- Resource use data

To ensure a smooth transition, residents or their representatives (sponsors) are requested to provide a minimum of 72 hours' notice before discharge. This allows for a thorough discharge evaluation and the development of a comprehensive post-discharge plan.

A member of the Interdisciplinary Team (IDT) reviews the final post-discharge plan with the resident and family at least 24 hours before discharge. Additionally, the following documents are provided to both the resident and the receiving facility, with a copy retained in the resident's medical records:

- Evaluation of the resident's discharge needs
- Post-discharge plan
- Discharge summary

A sample of a discharge plan is attached as **Exhibit 12.**

Transfer policies are also attached as **Exhibit 13**.

(d) Provide access to the facility for all long term care home and community-based services education and outreach efforts approved by the Maryland Department of Health, the Maryland Department of Aging and the Maryland Department of Disabilities to provide education and outreach for residents and their families regarding home and community-based alternatives.

Applicant Response:
As described above, Residences at Vantage Point has been a cornerstone of aging services in Columbia and Howard County for 35 years, working collegially with organizations and agencies that serve elderly and/or infirm populations. Members of our leadership team and Board of Directors have volunteered their time to serve and lead these organizations throughout our history.

Our strong partnerships with community service providers across the county, including collaborations with other long-term care providers, and the aforementioned relationships with Gilchrist Hospice and home health agencies such as Bayada Home Health Care and BrightStar Care ensure that, if awarded the CON beds currently under review, we will continue to provide exceptional alternative placement and discharge planning for future residents.

In order to document RVP's commitment to providing long term home care and community-based care alternatives please see the letters from area health care providers at **Exhibit 9.**

(4) Appropriate Living Environment.

Applicant Response:

As background for the responses to this standard which follow, RVP seeks CON approval to allow 13 of its 44 nursing home beds (the "Beds"), currently restricted by CON exemption to usage by CCRC residents of RVP, to become available to the public (the "Project"). The building in which the Beds are located was built in 1990 in compliance with all applicable codes and regulations in effect at that time and has not had a major upgrade since then. RVP is rated by the federal Centers for Medicare and Medicaid Services as a 5-Star facility and is currently licensed and Medicare certified and operating without waivers of any kind. The Project solely involves conversion of the status of the Beds, without any renovation or construction being necessary to do so. CON approval requires, among other things, compliance with relevant portions of the Chapter.

This section of the Chapter requires compliance with the FGI Guidelines (the "Guidelines") for projects subject to the standard that are applicable to an "Appropriate Living Environment" ("ALE"). Part (a) seeks a demonstration of compliance with the Guidelines regarding an "appropriate living environment," a term having no further definition. Parts (b) and (c) apply to projects with new construction or renovation respectively, and identify requirements regarding patient rooms (beds, temperature controls, toilets), and an overall non-institutional nursing home design that is more home-like. Part (d) requires a design architect's attestation that the "project" (as contrasted with the facility as a whole) complies with the Guidelines, and that each "design element of the project" is justified if there are deviations from the Guidelines. The Guidelines, by their own definition, apply only to construction and "major" renovation projects, and even then, they apply only to areas of a facility involved in the construction/renovation, rather than the facility as a whole. Certainly, this makes it challenging to assess the Guidelines in relation to a project that does not involve any construction/renovation, though at the same time it is understandable that the Commission would want to know how an "appropriate living environment" is provided even if there is no construction/renovation.

As further context for the analysis which follows, we observe that the Guidelines publication is more than 300 pages long, identifying hundreds of individual standards. While the Guidelines in their entirety do not apply exclusively to nursing homes because other types of residential facilities are included, the sections entitled "General," "Common Elements for Residential Health, Care and Support Facilities," and "Specific Requirements for Nursing Homes" would be applicable for nursing home construction/renovation projects. Those sections represent more than half of the entire Guidelines publication. Thus, even providing some reasonable assessment of RVP's status vis a vis the Guidelines represents an enormous undertaking, given that the Project entails no construction/renovation.

Since the term "appropriate living environment" is not defined it is necessary to look more closely at the intent of Section .05A(4) of the Chapter and how this section might be applied to a project that does not involve construction/renovation. In looking at the scope of what is identified in the standards in this section, it is evident that "living environment" as may fairly be assessed concerns what residents experience with respect to the facility as a resident's home, rather than what a resident experiences in the facility as a treatment setting. For example, in one of the few specific examples of what the Chapter identified as illustrative of an appropriate living environment, the standard is concerned with the ability of a resident to

control the thermostat for heating and cooling in the resident room, rather than being concerned with the institutional HVAC system characteristics. The only other specific examples of the Chapter's focus on ALE relate to the number of beds in a room, the resident toileting facilities (as contrasted with the institutional plumbing system), and the provision of a more home-like rather than institutional setting.

Though the Project does not involve any construction/renovation and does not require the involvement of an architect for the simple conversion of restricted beds to public beds, RVP did consult an architect to help determine what might reasonably be defined as ALE and the relevant Guidelines if the Project were to be assessed relative to Guidelines applicable to renovation projects.

In this context the ALE of a resident for the RVP Project that would be subject to Chapter standards at its core primarily includes bedrooms and bathrooms that are directly affected by their availability for public use, and other areas of the facility which a resident would utilize in the course of normal daily living, such as dining and recreation areas. The "living environment" of a residence would not include areas of a nursing home as a health care provider otherwise subject to the Guidelines such as patient care treatment areas, staff areas, MEP (mechanical, electrical, plumbing) systems, HVAC, structural considerations, and areas not directly affected by the project. This overview is fully consistent with the Guidelines as well, which (as will be further explained below) contain very specific sections on "Specific Requirements for Nursing Homes," including standards for "Resident Areas" and "Common Areas."

Further, it is also important to note that the Guidelines differ for construction vs. renovation projects, with new construction being subject to more rigorous standards as might be expected, since a renovation project is locked into constraints of an existing structure. Given that the Project involves neither, we felt it would be compliant with the Chapter to look at illustrative examples of the more relevant and material renovation standards related to a resident's daily living environment to provide an assessment.

Attached as **Exhibit 14** is an architect's letter addressing compliance with Guidelines with respect to the Project and provision of an "appropriate living environment," consistent with the discussion above. Note that the letter indicates reliance in some degree on information provided by the CEO of RVP, since the Guidelines include standards that require a mixture of both qualitative and quantitative assessments, requiring appropriate underlying information to be provided by both individuals.

It is within this framework that RVP offers the following detailed information addressing the Chapter standards, and additional information supporting compliance with the spirit and intent of the Guidelines relevant to the provision of an "appropriate living environment."

(a) An applicant shall provide each resident an appropriate living environment that demonstrates compliance with the most recent Facility Guidelines Institute's Guidelines for Design and Construction of Residential Health, Care, and Support Facilities (FGI Guidelines).

Applicant Response:

Part 3 of the Guidelines addresses "Residential Health Facilities." Section 3.1 of the Guidelines is entitled "Specific Requirements for Nursing Homes." Within that subsection, there are numerous cross-references to other sections of the Guidelines, incorporating them by reference, including references to Part 1 General, and Part 2 Common Elements for Residential Health, Care and Support Facilities. Thus, all Guidelines applicable to nursing homes are identified and encompassed within Section 3.1. Those sections that are relevant to the RVP Project will be addressed here within the ALE framework for review that has been outlined above.

Section 3.1-1.4 in the Nursing Home section of the Guidelines addresses Safety Risk Assessment factors, which are more specifically enumerated in Section1.2-4 that apply to all residential facilities. Some of the sections that apply to ALE involve assessments of such risk factors as resident mobility, medication safety, falls, security, disaster and emergencies.

As part of its comprehensive Quality Assurance Program, the facility implement a Risk Mitigation Program designed to proactively identify, assess, and address potential safety concerns for all residents. This program operates through routine meetings, where interdisciplinary teams review data, analyze trends, and implement corrective actions to reduce risks effectively. Below is a breakdown of key components of the Risk Mitigation Program, aligned with the Safety Risk Assessment (SRA) framework:

Infection Control

To ensure a robust infection control strategy, the facility employs a full-time registered nurse dedicated to overseeing the Infection Control and Disease Prevention Program. This program is designed to minimize the spread of infectious diseases and maintain a safe living environment. Key elements include:

- Routine audits of infection control protocols to ensure compliance with regulatory standards.
- Ongoing staff training on infection prevention best practices.
- Resident and visitor education on hygiene, vaccination programs, and outbreak response measures.
-

Resident Mobility and Transfer Safety

To mitigate risks associated with mobility challenges, the facility partners with a third-party therapy provider to conduct:

- Comprehensive screenings upon admission to assess each resident's mobility status.
- Ongoing reassessments throughout a resident's stay to monitor changes in physical function.
- Early intervention strategies, such as therapy referrals, assistive devices, and caregiver training, to reduce the likelihood of falls and transfer-related injuries.

Fall Risk Prevention

Falls are a leading concern in senior living communities. To address this risk, the facility implements a data-driven fall prevention strategy, which includes:

- Monthly tracking and trending of fall incidents to identify patterns and risk factors.
- Proactive interventions, such as environmental modifications, individualized care plans, and staff training.
- Multidisciplinary review meetings to evaluate the effectiveness of fall prevention efforts and implement continuous improvements.

Medication Safety

The RVP facility ensures resident safety through a dedicated medication room and secure medica carts. Additionally, its contracted pharmacy partner routinely monitors medication management as part of our quality assurance program. Policies and procedures are continuously updated to maintain compliance with state and federal regulations, reinforcing the facility's commitment to resident well-being.

Dementia and Behavioral Health Support

As managed by Life Care Services, the facility is certified at the Gold level for the Heartfelt Connections program, which provides specialized care for residents with Alzheimer's, dementia, and behavioral health needs. Staff receive annual training in evidence-based, person-centered care and conduct initial screenings and ongoing monitoring to support residents' psychosocial well-being.

Disaster and Emergency Preparedness

RVP is committed to maintaining a comprehensive emergency preparedness program to ensure resident safety. Emergency plans are reviewed and updated annually and undergo regular audits by state surveyors to ensure compliance with evolving regulations. With these proactive measures in place, RVP is confident in its ability to respond effectively to emergencies and protect our residents.

Though RVP may not meet every present Guideline exactly as stated, every Safety Risk Assessment topic is addressed in policies and procedures, and implemented accordingly, fully consistent with the spirit and intent of the Guidelines that would apply to a renovation project. Through these structured initiatives, the Risk Mitigation Program fosters a culture of safety, ensuring residents receive the highest level of protection and care.

Section 3.1-2.2.3 contains Resident Room Requirements for Renovation. The subsection on Capacity requires no more than 4 residents in a room. None of the RVP rooms has, or will have, more than 2 residents.

Space requirements (Section 3.1-2.2.3.2) indicate renovations must allow the rooms to accommodate a bed, or recliner if preferred by the resident, closet or dresser for clothes, and a nightstand. RVP currently meets this standard.

Rooms must have a window (Section 3.1-2.2.3.3). RVP complies with this standard.

The requirements for resident Privacy (Section 3.1-2.2.3.4) include visual privacy in multiple resident rooms, without impairing access to toilets, the room entrance, the window or other common areas in the room. Each semi-private room is equipped with a curtain that separates the two sides of the room. Residents can choose to draw these curtains at their convenience.

Further specific requirements are provided for a Handwashing Station which may be omitted if other requirements are met (Section 3.1-2.2.3.5), Resident toilet room (Section 3.1-2.2.3.6), and Resident bathroom (Section 3.1-2.2.3.7).

In resident rooms, there are a few current deviations from the Facility Guidelines Institute (FGI) standards:

- Grab bars are installed at the rear and side of toilets; however, not all rear grab bars meet the 36" length requirement, and not all side grab bars are the full 42" length.
- In bathrooms with tubs, grab bars are provided on all walls within the tub enclosure. While the grab bar on the control wall is not 24" in length as specified, it is supplemented by an additional vertical grab bar to assist with resident safety.
- In some bathrooms, where the sink overlaps with the toilet floor clearance zone, the overall bathroom depth measures 60", falling short of the 66" minimum required by current FGI guidelines.

Despite these minor deviations, community operations prioritize resident safety and comfort. In collaboration with residents and the RVP therapy team, additional assistive devices have been installed to mitigate any potential impact. These adaptations ensure the overall resident experience remains safe and supportive. Additionally, residents are provided with showering facilities in the Central Bathing Area. There is not a handwashing station in the Central Bathing area. However, the community's current operations utilize the in-room toilet and hand washing stations to ensure the proper hygiene of all residents. Grab bars, moveable seats, and appropriate space/equipment for showering assistance are provided in each shower in the Central Bathing area.

In short, the operational efficiency and proactive approach of the facility ensure that these deviations from FGI guidelines have minimal impact on resident well-being. Importantly, while the environment may not fully align with the most recent FGI specifications pertaining to the ALE the facility remains fully compliant with all applicable regulations for operational use. This is further evidenced by consistently high standards of care and above-average performance in regulatory surveys over the past several years.

Section 3.1-2.3 deals with Dining, Recreation an Activity Areas. Dining Facilities (Section 2.1-2.3.2) requires that the facilities encourage use by residents, participants and visitors, and that the dining facilities may also be used for other activities. A central dining facility must have space to accommodate the needs of its residents, space to access and leave without disturbing others, allow clear paths for servers and food carts to circulate, and space to allow caregivers to provide assistance to those needing it.

The current dining and activity area on the unit is thoughtfully designed to accommodate residents' diverse needs and preferences. The dining space offers a comfortable and inviting environment where residents can enjoy their meals at their own pace, fostering both social

interaction and independence. Similarly, the activity area provides a variety of engaging programs and recreational opportunities, allowing residents to participate based on their interests and abilities. The flexible layout and inclusive approach ensure that residents can seamlessly transition between dining and activities, enhancing their overall quality of life and sense of community.

Section 3.1-2.3.3 concerns Recreation, Lounge and Activity Areas. These areas must have enough space to accommodate resident activities and the associated equipment, allow groups of different sizes to participate, and accommodate separate activities.

The facility currently has a dedicated multipurpose space that encourages residents to lounge in a sun-filled space at their leisure or participate in an array of activities. Our current activities calendar is robust and geared toward the collective needs of residents. The activity space has easy access to board games and puzzles and also is flexible for utilization for games and group activities.

Section 3.1-2.3.4 identifies requirements for Outdoor Activity Areas. Direct access to safe outdoor areas should be provided and encouraged as appropriate to the location.

Residents have multiple options for accessing outdoor spaces within the community. On the second floor, a covered terrace provides a comfortable area where residents can gather and socialize as they wish. Additionally, the activities team frequently utilizes Sidwell Garden, a beautifully maintained outdoor space located at the rear of the community. This serene area features lush greenery, ample seating, and abundant shade, offering residents a peaceful environment to relax, engage in activities, and enjoy the outdoors.

(b) If an applicant is proposing a project that involves new construction, the applicant shall:

(i) Develop rooms with no more than two beds for each resident room[4];

(ii) Provide individual temperature controls for each room;

(iii) Assure that no more than two residents share a toilet; and

(iv) Identify in detail, by means of architectural plans or line drawings, plans to develop a nursing home that provides a cluster/neighborhood design or a connected household design, rather than an institutional design, consistent with the most recent FGI Guidelines.

Applicant Response:

This standard is not applicable because the Project does not involve new construction. Nonetheless, we note that none of the beds to be added will be in a room having more than

[4] FGI Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, 2022 Edition, Appendix A3.1-2.2.2.1.

two residents. Each room does have individual temperature controls, and no more than two residents share a toilet.

(c) If an applicant is proposing a project that involves renovation or expansion, the applicant shall:

(i) Reduce the number of resident rooms with more than two residents per room, with single resident rooms preferred;

(ii) Provide individual temperature controls in each newly renovated or constructed room;

(iii) Reduce the number of resident rooms in which more than two residents share a toilet; and

(iv) Document that the applicant considered development of a cluster/neighborhood design or a connected household design, and, if the project includes an institutional model, document why the alternative models were not feasible.

Applicant Response:

This standard is not applicable because the Project does not involve renovation or expansion. Nonetheless, we note that none of the beds to be added will be in a room having more than two residents. Each room does have individual temperature controls, and no more than two residents share a toilet.

(d) The applicant shall demonstrate compliance with COMAR 10.24.20.05A (4) by submitting an affirmation from a design architect for the project that:

(i) The project complies with applicable FGI Guidelines; and

(ii) Each design element of the project that deviates from the FGI Guidelines is justified by specific stated reasons.

Applicant Response:

An affirmation from an architect is attached as **Exhibit 14** regarding compliance of the Project with applicable FGI Guidelines. See the excerpt below referencing any deviations from the current FGI Guidelines (emphasis added).

> *"…The project deviates from specific FGI requirements in some respects primarily because it was built long before the current FGI Guidelines came into effect.* ***In those instances in which there are deviations from current FGI requirements, the facility has implemented alternative or supplemental measures to uphold the intent of these guidelines.*** *The measures detailed in the Letter outline that the facility meets regulatory expectations.*

Additionally, we understand that the facility has established policies and procedures to address any areas where physical deviations are found to occur, further supporting compliance with industry best practices and regulatory requirements…"

(5) Specialized Unit Design.

An applicant shall administer a defined model of resident-centered care for all residents and, if serving a specialized target population (such as Alzheimer's, respiratory, post-acute rehabilitation) demonstrate that its proposed facility and unit design features will best meet the needs of that population. The applicant shall:

(a) Identify the types of residents it proposes to serve, their diagnostic groups, and their care needs;

(b) If developing a unit to serve respiratory residents, demonstrate the ability to meet Office of Health Care Quality (OHCQ) standards in COMAR 10.07.02.24;

(c) If developing a unit to serve dementia residents, demonstrate the ability to meet OHCQ standards and the most current FGI Guidelines; and

(d) Demonstrate that the design of the nursing home is consistent with current FGI Guidelines and serves to maximize opportunities for ambulation and self-care, socialization, and independence. An applicant shall also demonstrate that the design of the nursing home promotes a safe and functional environment and minimizes the negative aspects of an institutional environment.

Applicant response:

In response to Part a), At RVP we provide care for a diverse population of geriatric patients, each with unique needs and medical conditions. Our residents often face a range of chronic illnesses such as diabetes, hypertension, and heart disease, as well as neurodegenerative disorders like Alzheimer's and Parkinson's. Many also require management for mobility challenges, arthritis, and sensory impairments, while others may need specialized support for post-operative recovery or palliative care. In addition, we care for individuals with varying levels of cognitive decline, ensuring personalized treatment plans that promote dignity, comfort, and quality of life. Our team is dedicated to delivering compassionate, individualized care that meets the physical, emotional, and psychological needs of every resident.

Parts b) and c) are not applicable, as RVP does not provide dedicated units for respiratory of dementia patients.

With regard to Part d) – which addresses consistency with the FGI Guidelines – see our response to the standard immediately above (Appropriate Living Environment).

(6) Renovation or Replacement of Physical Plant.

An applicant shall demonstrate how the renovation or replacement of its nursing home will:

(a) Improve the quality of care for residents in the renovated or replaced facility;

(b) Provide a physical plant design consistent with the FGI Guidelines; and

(c) If applicable, eliminate or reduce life safety code waivers from the OHCQ and the Office of the Maryland State Fire Marshal.

Applicant's Response:
Not Applicable, as there will be no renovation or construction of any kind related to this request to convert CCRC-restricted beds to publicly available beds.

(7) Public Water.
Unless otherwise approved by the Commission and the OHCQ in accordance with COMAR 10.07.02.43, an applicant shall demonstrate that its facility is, or will be, served by a public water system that meets the Safe Drinking Water Act standards of the Maryland Department of the Environment.

Applicant's Response:
The Residences at Vantage Point receives its water from Howard County.

(8) Quality.

The applicant shall demonstrate that it will provide high quality of care, as determined by an assessment of the following information requested in subsection (8)(a)-(g).

(a) **An applicant shall report on its overall CMS Five Star Rating for all the nursing homes owned or operated by the applicant or a related or affiliated entity for three years or more, for the five quarterly refreshes for which CMS data is reported preceding the date of the applicant's letter of intent submission, or submission date for other Commission approval.**

(i) If the applicant or a related or affiliated entity owns or operates one or more nursing homes in Maryland, the CMS star ratings for Maryland facilities shall be used.

(ii) If the applicant or a related or affiliated entity does not own or operate nursing homes in Maryland, the applicant shall select the state or states in which it owns the most facilities and the CMS star ratings for such facilities shall be used.

Applicant's Response:
RVP is the only nursing home operated by the applicant. It has achieved overall ratings of 5 stars for each of the previous five quarters as measured by Medicare.

CMS Five Star Rating for Letter of Intent submitted December 20, 2024

Oct-Dec 23	Jan-March 24	April-June 24	July-Sept 24	Oct-Dec 24
5 stars	5 stars	5 stars	5 stars	5 stars

Source: Data was accessed December 20, 2024, from medicare.gov/care-compareData files from December, September, June and March of 2024 and December 2023

(b) If any facilities identified under paragraph (a) has an average star rating below 3 stars, the applicant shall provide a detailed quality rating analysis demonstrating good cause for not meeting the CMS star rating threshold and that the applicant is likely to provide adequate quality of care in the nursing home subject to the request.

Applicant's Response:
Not applicable. No nursing home operated by RVP had an average star rating below 3 stars. As shown immediately above, RVP is the only nursing home operated by the applicant, and has achieved overall ratings of 5 stars for each of the previous five quarters.

(c) The applicant shall address whether any nursing home currently or previously owned by the applicant or a related or affiliated entity, within or outside the State, for the period of 3 years immediately preceding the submission of the letter of intent or request for other Commission approval was the subject of an enforcement action, a special focus facility designation, or a deficiency involving serious or immediate threat, actual harm, or immediate jeopardy to a resident. The applicant shall describe what measurable efforts it has taken to address the deficiencies.

Applicant's Response:
Not applicable. No nursing home owned by RVP has been the subject of an enforcement action, a special focus facility designation, or a deficiency.

(d) The applicant shall address whether any nursing home currently or previously owned by the applicant or a related or affiliated entity, within or outside the State, for the period of 3 years immediately preceding the submission of the letter of intent or request for other Commission approval was the subject of a lawsuit judgment or an arbitration finding, following a complaint filed by a resident, resident

representative, or a government agency. The applicant shall provide an explanation of the circumstances surrounding the judgment or finding and subsequent actions taken.

Applicant's Response:
Not applicable. No nursing home owned by RVP has been the subject of a lawsuit judgment or an arbitration finding, resulting from a complaint filed by a resident, resident representative, or a government agency.

(e) An applicant shall demonstrate appropriate infection prevention and control by providing the percent of residents receiving COVID, flu and pneumonia vaccinations, and the percent of staff receiving COVID, flu and pneumonia vaccinations:

(i) At the nursing home that is the subject of the request, for a CON or exemption request; or

(ii) At the nursing homes identified under §(8)(a), for a request for acquisition approval.

Applicant's Response:
Vaccination data shown below.

Vaccination	Per Cent of Residents Receiving Vaccination	MD Average	Per Cent of Staff Receiving Vaccination	MD Average
COVID	88.9	44.6	2.9	9.2
Flu	92.7	77.9	30.7	76
Pneumonia	74.8	78.2	NA	NA

Source: Maryland Health Care Commission Quality Reports, https://healthcarequality.mhcc.maryland.gov/NursingHome/Detail/109

(f) If the applicant or a related affiliated entity owns or operates or previously owned Maryland nursing homes, it shall report its rating of overall care and percent satisfied for the most recent three years on the MHCC Family Experience of Care Survey, reporting on any trends in the results. If the facility's average rating of overall care is below 7.0, the applicant shall document efforts to improve the facility's rating. If the facility's average percent satisfied overall rating is below 70 percent, the applicant shall document efforts to improve the facility's rating.

Applicant's Response:
Vantage Point participates in the Maryland Health Care Commission (MHCC) Family Experience of Care Survey annually. This survey is conducted by an independent third-party vendor to ensure objectivity and consistency across all participating facilities.

However, at the conclusion of the survey window each year, we have been informed that an insufficient number of residents and/or their representatives completed the survey to meet the eligibility threshold for reporting. As a result, we have not received published results for the most recent three-year period and are therefore unable to report trends or provide average ratings for overall care or percent satisfied.

Despite this limitation, Vantage Point remains fully committed to the MHCC survey process and will continue to partner in this important program. We believe this initiative is a valuable tool for measuring and improving resident and family satisfaction, and we will continue to encourage robust participation in future survey cycles.

If awarded the additional beds, we are optimistic that increased census and engagement will lead to a higher survey response rate, allowing us to meet the eligibility threshold and be included in future reporting.

(g) Quality Assurance.

(i) An applicant shall demonstrate that it has an effective quality assurance program in each nursing home facility that is owned or operated by the applicant or a related or affiliated entity for the period of 3 years immediately preceding the submission of the letter of intent or request for other Commission approval by providing the Commission with a schedule of its quarterly Quality Assurance meetings.

(ii) An applicant that has never owned or operated a nursing home shall provide documentation that demonstrates a thorough understanding of assessing quality assurance in a long term care facility or related facility/program. Include any documentation of a prior assessment that reviewed quality metrics, a review of operations, and regulatory compliance and include any subsequent follow up in the form of actions taken, results, or improvement plans.

Applicant's Response:
RVP's Quality Assurance committee meets on a quarterly basis. The schedule of meetings for the three years prior to submitting our letter of intent is shown below.

2022: Jan 18th; Feb 15th; Mar 15th; Apr 19th; May 17th; Jun 21st; July 19th; Aug 16th; Sept 20th; Oct 18th; Nov 15th; Dec 13th

2023: Jan 17th; Feb 21st; Mar 21st; Apr 18th; May 16th; Jun 20th; July 18th; Aug 15th; Sept 12th; Oct 17th; Nov 21st; Dec 19th

2024: Jan 16th; Feb 20th; Mar 19th; Apr 16th; May 21st; Jun 18th; July 16th; Aug 20th; Sept 17th; Oct 15th; Nov 19th; Dec 17th

2025: Jan 21st; Feb 18th; Mar 18th; Apr 22nd; May 20th

See **Exhibit 15: TYPICAL QA AGENDA AND ATTENDEES** which illustrates the participants in and subject matter considered at these meetings. As needed, quality improvement initiatives originate with this committee, which then follows up to monitor results.

(9) Collaborative Relationships.

(a) An applicant shall document its relationships with hospitals, hospice programs, home health agencies, assisted living providers, Assessments Evaluation and Review Services[5], adult day care programs, and other community providers in the long-term care continuum. This may include contracts, letters or other relevant documentation.

Applicant's Response:
RVP maintains strong working relationships in the health care community, as documented below. Copies of contracts and letters documenting collaboration are attached as **Exhibit 16.**

Provider Class	Provider	Nature and documentation of Relationship
Hospitals	Howard County General Hospital	Referring hospital provider (contract provided)
Hospice Programs	Gilchrist	In-home, or in-patient hospice provider (contract provided)
	Accent Care (formerly Seasons)	In-home hospice care (contract provided)
Home Health Agencies	Bayada	Home Health referral provider
	BrightStar Care	Home health and home care referral provider
Assisted Living Facilities	Morning Side	Assisted Living provider
	Harmony Hall	Assisted Living provider
	Copper ridge	Assisted Living provider

RVP has initiated contact with the Howard County Health Department in order to implement the AERS process to ensure appropriate placement of individuals needing long term care, as evidenced by correspondence with Renee Bitner, AERS/Nurse Monitoring **(Exhibit 16).**

[5] In January of 2025, there was a renaming of the Adult Evaluation and Review Services to Assessments Evaluation & Review Services, reflective of the broader population assessed. The acronym (AERS) remains the same.

(b) An applicant shall demonstrate its commitment to effective collaboration with hospitals by documenting its successful efforts in reducing inappropriate readmissions to hospitals, improving the overall quality of care, and providing care in the most appropriate and cost-effective setting. The demonstration shall include:

(i) Data showing a reduction in inappropriate hospital readmissions; and

(ii) Data showing improvements in the quality of care and provision of care in the most appropriate setting.

Applicant's Response:

RVP's measures on hospitalization of residents and especially emergency room visits compare favorably with peers as shown in data provided by CMS.

Percentage of short-stay residents who were re-hospitalized after a nursing home admission *Lower percentages are better*	25% National average: 25% Maryland average: 23.4%
Percentage of short-stay residents who have had an outpatient emergency department visit *Lower percentages are better*	5.3% National average: 12.8% Maryland average: 10.5%
Number of hospitalizations per 1,000 long-stay resident days *Lower numbers are better*	2.36 National average: 1.84 Maryland average: 1.33
Number of outpatient emergency department visits per 1,000 long-stay resident days *Lower numbers are better*	0.77 National average: 1.74 Maryland average: 1.18

Source: DATA,CMS,Gov Quality Measures https://data.cms.gov/provider-data/topics/nursing-homes/quality-measures#quality-measure-data-collection-periods

(c) An applicant shall demonstrate its commitment to providing an effective continuum of care by documenting its collaborative efforts with Medicare-certified home health agencies and hospices to facilitate home-based care following nursing home discharge and

shall facilitate delivery of hospice services for terminally ill residents. The demonstration shall document that the applicant has:

(i) Planned for the provision of home health agency services to residents who are being discharged; and

(ii) Arranged for hospice and palliative care services, when appropriate, for residents who are being discharged.

Applicant's Response:
See letters and contracts provided above in response to Part a) of this standard from Gilchrist, and Bayada. **(Exhibits 9 and 16).**

Criteria for Review Continued:

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated a need for the proposed project.

INSTRUCTIONS: *Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.*

If the current bed need projection published by the MHCC based on the need formula in the State Health Plan does not project a need for all of the beds proposed, the applicant should identify the need that will be addressed by the proposed project by quantifying the need for all facility and service capacity proposed for development, relocation, or renovation in the project.

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

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

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

Applicant's Response:

We will discuss five data points that support the need for this 13 bed addition to the nursing home bed inventory of Howard County:

- MHCC's latest need projection shows a need for 13 beds;
- The target population in Howard County is growing at a rate that well exceeds the statewide rate, while…
- The per capita supply of nursing home beds relative to the target population is among the lowest (23rd out of 24 jurisdictions) in the state;
- Howard County Nursing homes deliver a higher percentage of their patient days to patients paid for by the Medicaid program than most of the state's other jurisdictions;
- The occupancy rates for Howard County nursing homes have been consistently among the stronger of Maryland's 23 jurisdictions across the last decade.

Discussion:

1. The proposed project is consistent with the applicable need standard and need projection methodology in the State Health Plan. The latest MHCC need projections show a need for 13 additional beds in Howard County.[6]

2. Analysis of population projections shows a significant growth in the cohorts most likely to need nursing home care. The table below shows that the population of Howard County residents 70 or older will increase by 17,000 – 41 per cent – between 2025 and 2035. By comparison, the statewide projected increase in these cohorts is 34 per cent over that decade.

	70-74	75-79	80-84	85+	Total
2020	13,312	9,204	5,493	4,847	32,856
2025	15,175	12,329	7,786	6,047	41,337
2030	17,257	14,083	10,423	8,226	49,989
2035	19,085	16,048	11,954	11,343	58,429

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

3. Howard County is 23rd out of 24 jurisdictions in Maryland in the ratio of nursing home beds to the target population, for all three cohorts (65+, 75+, 85+).[7] In fact, the

[6] MHCC Nursing Home Bed Need Projections – Target Year 2022
https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_ltc/documents/chfc_ccf_bedneed_projections_target2022_20190927.pdf

[7] Nursing Home Resident Profile, Table 1.8 Comprehensive Care Beds Per 1,000 Population and Rank by Age Group and Jurisdiction: Maryland Calendar Year 2020
https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_ltc/documents/Routine%20Reports%20All%20Tables%2011_14_22%20FINAL.pdf

discrepancy between the Howard County and State of Maryland ratios is stunning; in each cohort, the state average is more than double that of Howard County.

	BEDS PER 1,000 POPULATION 65+ YEARS	BEDS PER 1,000 POPULATION 75+ YEARS	BEDS PER 1,000 POPULATION 85+ YEARS
Howard Co.	12.15	30.91	124.61
Maryland	28.62	70.06	228.52

Source: Nursing Home Resident Profile, Table 1.8 Comprehensive Care Beds Per 1,000 Population and Rank by Age Group and Jurisdiction: Maryland Calendar Year 2020

4. Howard County Nursing Homes Serve a Higher Percentage of Medicaid Beneficiaries. Although the most recent available data is from 2020, the nursing homes in Howard County appear to deliver a higher ratio of days of care to Medicaid patients than the statewide average by a considerable margin, at 70% compared to the statewide rate of 63.4%. This places Howard County 9th out of 24 jurisdictions,

Jurisdiction	% of Nursing Home days Paid by Medicaid Program, 2020
Dorchester County	78.8
Garrett County	76.5
Baltimore City	73.8
Carroll County	73.2
Wicomico County	72.8
Charles County	71.5
Caroline County	71.1
Queen Anne's County	70.3
Howard County	**70.0**
Somerset County	69.9
Maryland	**63.4**

Source: Nursing Home Resident Profile, Table 1.6, Trends in Percentage of Nursing Home Patient Days Paid for by Medicaid Program: Maryland, Selected Fiscal Years, 2010 - 2020

5. Howard County's Nursing Home Occupancy Rates Have Been Relatively High.
Although occupancy rates across the state declined post-Covid, they are gradually normalizing. The occupancy rate ranking of Howard County nursing homes compared to other Maryland jurisdictions trended upward in rank by jurisdiction between 2014 and 2020, moving from a rank of 15th in 2014, to 5th in 2017 to 4th, 6th, and 8th, in 2019, 2020, and 2021 respectively, before settling into the middle of the pack 13th in 2022.

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022
Rank among 23 Jurisdictions	15	11	8	5	7	4	6	8	13

Sources: Nursing Home Resident Profile, Table 1.4, Nursing Home Occupancy Rate Percentage by County: Maryland, Fiscal Years 2014- 2020, and Average Annual Bed Occupancy Rate and Average Annual Number of Licensed Nursing Home Beds by Jurisdiction and Region: Maryland, Fiscal Years 2020 - 2022

In summary, the need for this project is consistent with the latest MHCC projections. That need is further demonstrated by the fact that the target population in Howard County is growing at a rate that well exceeds the statewide rate, while the per capita supply of nursing home beds is among the lowest of Maryland's 24 jurisdictions. These factors converge to result in consistently healthy occupancy rates experienced by Howard County facilities.

It is also noteworthy that nursing homes in Howard County deliver a higher percentage of their patient days to patients paid for by the Medicaid program than most of the state's other jurisdictions. Thus adding 13 beds to a five-star facility would improve the options available to the population financed by Medicaid.

10.24.01.08G(3)(c). Alternatives to the Project.

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

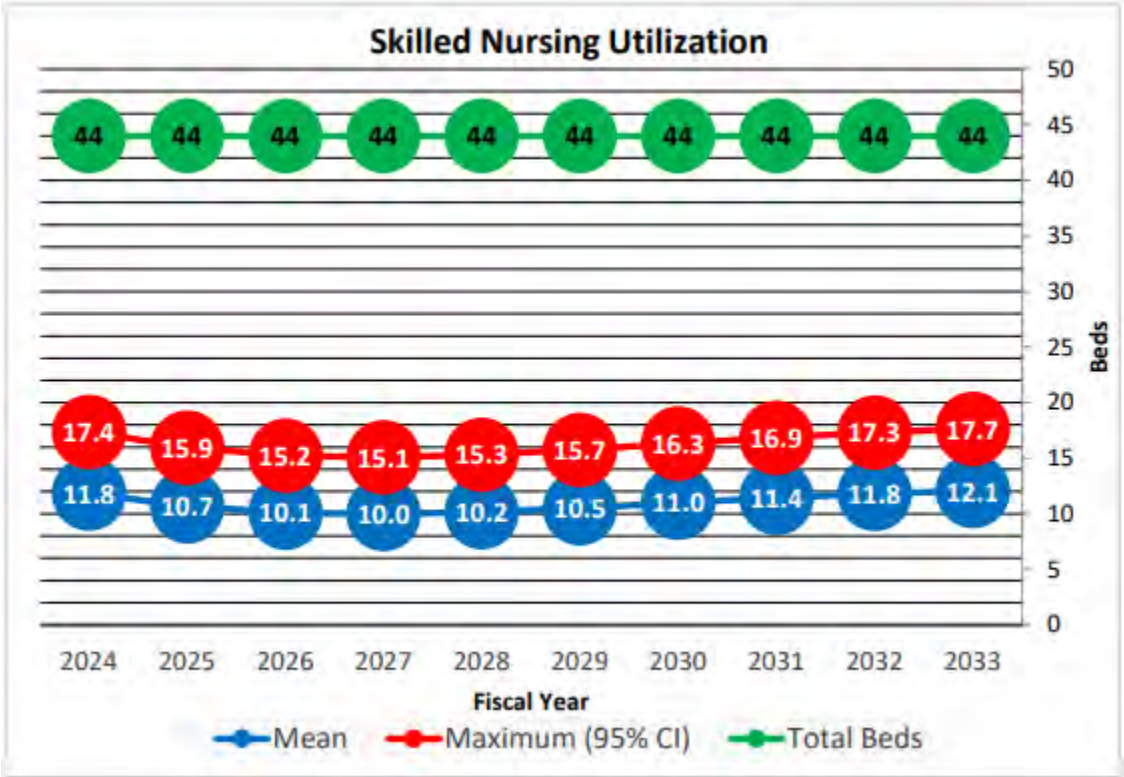
INSTRUCTIONS*: Describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project, or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those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

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

Applicant's Response:

Residences at Vantage Point (RVP) proposed this project to address the projected community need for additional nursing home beds by making its existing capacity available for public use. The facility has ample excess capacity compared to the projected demand of its CCRC residents, and thus can confidently make these beds available for public use.

The graphic below, from our actuarial study dated June 30, 2023 indicates that RVP's skilled nursing bed complement is comfortably more than likely to be needed.



Source: Residences at Vantage Point Comprehensive Actuarial Study as of June 30, 2023 by Continuing Care Actuaries
Note: The Mean is the average number of occupants per year based on actuaries' analysis, while the Max would be their projections for the highest average residents in a given year.

Given the small increment of beds available according to regulation, the only viable alternative way to supply these beds would be for another nursing home to add the 13 beds.

While RVP did not actively solicit interest from other facilities, the submission of our letter of intent ensured that the healthcare community was informed and had the opportunity to propose an alternative. However, no such interest was expressed, making RVP's proposal the only practical solution to meet this community need.
By making its surplus of CCRC-restricted nursing home beds available to the general public, the proposal would meet the projected need without incurring the construction cost that any other solution would require. This strategy is highly cost-effective, as it requires no capital investment.

10.24.01.08G(3)(d). Project Financial Feasibility and Facility or Program Viability.

The Commission shall consider the availability of resources necessary to implement the project and the availability of revenue sources and demand for the proposed services adequate to ensure ongoing viability and sustainability

of the facility to be established or modified or the service to be introduced or expanded.

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

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

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

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

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

- *Explain how the applicant will be able to implement the project in compliance with its implementation schedule (Part 1, Question 15). Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds*

within the estimated time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

Applicant's Response:

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

This proposed project requires no financial investment from RVP and is expected to enhance the organization's financial performance. By increasing utilization of RVP's 44 nursing home beds by approximately 50% (see Table D in the Tables Package), the initiative will generate significant new revenue streams. Specifically, allocating 13 beds for public use is projected to increase net operating revenue by over $1.24 million, while incurring less than $1.08 million in additional operating costs (Table G). This favorable cost-to-revenue ratio will contribute to positive operating margins across the enterprise in both the current and future fiscal years (Table F).

While RVP experienced net losses in 2023 and 2024, the organization is now positioned for a return to profitability, with projections indicating sustained positive margins moving forward. As is typical for Continuing Care Retirement Communities (CCRCs), RVP's financial resilience is supported by revenue from the turnover of independent living units. Additionally, reported operating losses were influenced by non-cash expenses such as depreciation and amortization, which do not impact cash flow.

In summary, RVP is on a solid financial footing, and this project represents a strategic opportunity to further strengthen its financial outlook. The initiative will not only enhance operational efficiency but also ensure the long-term sustainability of this vital community resource.

See **Exhibit 17** for audited financial statements.

Exhibit 18 shows correspondence demonstrating community support.

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

An applicant shall demonstrate compliance with all terms and conditions of each previous CON granted to the applicant.

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

Applicant's Response:
Not applicable, as the applicant has not applied for a previous Certificate of Need.

10.24.01.08G(3)(f). Project Impact.

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

INSTRUCTIONS: *Provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:*

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

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

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

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

Applicant Response:
Responding to subparts a) and b), it is fair to say that in a planning region (Central Maryland) that is currently supplied with 12,114 licensed nursing home beds, 576 of which are in Howard County[8], the impact that approving the requested 13 beds on the volumes, costs, charges, and payer mix of existing nursing home providers is virtually nil.

The small volume increase in total nursing home demand is likely to come from the natural aging of the service area population. Adding these 13 beds to the supply available to the

[8] GROSS, NET, AND EFFECTIVE BED NEED PROJECTIONS FOR COMPREHENSIVE CARE OR NURSING HOME BEDS, TARGET YEAR 2022
https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_ltc/documents/chfc_ccf_bedneed_projections_target2022_20190927.pdf

general public will entail the addition of 11 Certified Nursing Assistants (CNA) and one LPN. RVP does not anticipate difficulty filling those positions.

As for subpart c), the *impact on access to health care services*, the "macro effect" on access to those facilities and services for the population served would also have to be considered as a small incremental improvement. However, it should not be overlooked that patients whose payor is Medicaid will be gaining access to a previously-unavailable 5-star facility with high quality and satisfaction measures.

As an existing nursing home, RVP is asked to, *provide a summary description of the impact of the proposed project on costs and charges of the applicant nursing home.* At project maturity, operating expenses are projected to increase by about $1,075,000 while operating revenues are projected to grow by about $1,242,000.

The facility will benefit from significantly increased volume and occupancy rates. Projections at maturity show an expected 6,570 patient days consumed by the CCRC residents to be supplemented by 3,650 "public" patient days, a 56% increase. Thus fixed costs will be spread over a much larger patient base and incremental revenue comfortably exceeds incremental costs, strengthening the facility's economic viability.

10.24.01.08G(3)(g) Health Equity.

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

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

With health equity in mind, the applicant shall identify the specific medically underserved area(s)/group(s)[9] within the designated service area and outline how the proposed project will address the unique health needs and quality of care for each identified group.

Applicants are expected to furnish a detailed overview of their organization's expertise and experience in health care access and service delivery. Emphasis should be

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

placed on highlighting any relevant background that underscores the organization's commitment to equitable health care. This encompasses efforts to integrate implicit bias and cultural competency training within the health facility and among current staff members.

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

Applicant's Response:

Residences at Vantage Point has a longstanding tradition of delivering exceptional care and services to a diverse group of residents throughout greater Howard County. If awarded the 13 public beds, Vantage Point would be uniquely positioned to extend our award-winning services to an even broader population of seniors across Maryland. This opportunity would be especially impactful by allowing us to serve Maryland's Medicaid population for the first time in our history.

Expanding access to our CMS 5-Star rated facility for Medicaid-eligible residents would significantly enhance health equity by ensuring that high-quality, person-centered care is available to all, regardless of financial status.

Our commitment to advancing health equity extends beyond financial accessibility.

We are dedicated to providing culturally competent care that meets the diverse needs of Maryland's aging population. Our staff undergoes annual training on how to effectively engage with individuals from all backgrounds, ensuring that residents receive care that respects their cultural identities and personal experiences.

And for the second consecutive year, Vantage Point has been recognized with a Platinum Certification by SAGECare, an LGBTQ+ advocacy organization specializing in training elder care providers on best practices for serving LGBTQ+ seniors. This recognition underscores our ongoing efforts to foster an inclusive and affirming environment where all residents feel valued, respected, and empowered.

By expanding our services to Medicaid-eligible residents and continuing our commitment to culturally competent care, Residences at Vantage Point will further its mission of creating a more equitable and inclusive healthcare environment for all seniors in Maryland.

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

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

- *names/addresses of all owners and individuals responsible for the proposed project and its implementation. This includes any person with 5 percent or more ownership interest in the real property, bed rights or operations of the facility*
- *for each individual identified disclose any involvement in the ownership, development, or management of another health care facility*
- *for each individual and facility identified disclose if any license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last five years*
- *for each individual and facility identified disclose inquiries in the last from 10 years from any federal (e.g., CMS) or state authority (e.g., OHCQ), or other regulatory body regarding possible non-compliance with any state, or federal requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions*
- *disclose if any owners and individuals responsible for the project have identified above have ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities.*

Applicant's Response:

Residences at Vantage Point is a 501(c)(3) not-for-profit organization overseen by a volunteer Board of Directors (**Exhibit 19**). The Board does not hold an ownership stake in the corporation but serves as its primary compliance and fiduciary authority. The facility and its Board have maintained a strong record of regulatory compliance, with no adverse findings, guilty pleas, or citations from state or federal programs. As a CMS 5-Star rated facility, Residences at Vantage Point has a longstanding history of excellence in meeting state and federal standards. Notably, the facility has received zero citations for complaints or facility-reported incidents over the past three years.

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

LIST OF EXHIBITS

1. Lease
2. Facility Drawings
3. Other Health Care Facilities LCS Is Involved With
4. Board Authorization
5. MHCC Bed Need Projections For Nursing Home Beds, Target Year 2022
6. Letter Of Intent Medicaid Eligibility
7. CON Tables
8. Admission Criteria
9. Letters From Health Care Community Partners
10. Samples Of Materials Given To Prospective Admissions Describing Alternative Community-Based Services
11. MDS Policies
12. Example Of Discharge Plan
13. Transfer Policies
14. Architect FGI Letter
15. Typical QA Agenda And Attendees
16. Collaborative Relationships
17. Audited Financial Statements
18. Community Support
19. Roster, Board Of Directors
20. Affirmations

EXHIBIT 1

LEASE AGREEMENT

THIS LEASE AGREEMENT (the "Lease") dated as of October 1, 2000, for reference purposes, but effective as of the 16th day of November, 2000 ("Effective Date"), by and between VANTAGE HOUSE LLC, a Maryland limited liability company, or its assigns (hereinafter called "Lessor"), and COLUMBIA VANTAGE HOUSE CORPORATION, a Maryland corporation (hereinafter called 'Lessee").

RECITALS

Lessor desires to lease to Lessee and Lessee desires to lease from Lessor the Vantage House, a life care or continuing care community located at 5400 Vantage Point Road, Columbia, Maryland (the "Facility").

AGREEMENTS

NOW, THEREFORE, in consideration of the premises and the agreements hereinafter set forth, the parties hereby agree as follows:

ARTICLE I
Representations

1.1. Representations by Lessor. Lessor represents:

(a) that it is a limited liability company duly organized and validly existing with full power and authority to enter into this Lease and to perform its activities hereunder,

(b) that this Lease has been duly authorized, executed and delivered, and

(c) that this Lease, once executed, will be valid and legally binding on Lessor.

1.2. Representations by Lessee. Lessee represents:

(a) that it is a corporation duly organized, validly existing and in good standing under the laws of Maryland, with full power and authority to enter into this Lease and to perform its activities hereunder,

(b) that this Lease has been duly authorized, executed and delivered,

(c) that this Lease, once executed will be valid and legally binding on Lessee, and

(d) that it is a non-profit corporation exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of the United States (the "Code"), and a non-private foundation under Section 509 of the Code.

ARTICLE II
Demise, Term, Use and Rent

2.1. Premises. Lessor hereby does demise and let unto Lessee and Lessee hereby does lease and take from Lessor, for the term and upon the terms and conditions set forth in this Lease, all that certain tract of ground located on Vantage Point Road in Columbia, Maryland, as described in Exhibit A attached hereto and made part hereof (the "Land"), together with the buildings, parking areas, roadways and other improvements constructed thereon or used in connection therewith (the "Improvements"), (the Land and the Improvements being hereinafter collectively referred to as the "Premises").

2.2. Term.

(a) This Lease shall be for a term of ninety-nine (99) years plus that additional period between the Effective Date and the last day of the month in which the Effective Date occurs, commencing on the Effective Date and ending (unless sooner terminated as herein provided) on November 30, 2099.

(b) Lessor and Lessee are affiliated parties. It is their intent that this Lease shall only continue in full force and effect so long as Lessor owns the Premises, Lessor and Lessee are both in existence, and Lessor and Lessee remain affiliated parties. Therefore, in the event any such condition is at any time not satisfied, this Lease shall automatically terminate, unless both Lessor and Lessee agree otherwise. In the event of any such termination, all liability that either Lessor or Lessee had as of such date or may have had in the future shall terminate together with this Lease.

2.3. Use. The Premises shall be used for a residential continuing care facility, including all uses reasonably incidental thereto, and for no other purpose.

2.4. Annual Rent. Lessee agrees to pay to Lessor, throughout the term of this Lease, without notice or demand and without set-off or deduction, annual rent in the sum of One Dollar ($1.00), such amount being the actual and total consideration to be paid, there being no other money or other consideration paid or to be paid by Lessee to Lessor as rent or other consideration hereunder.

ARTICLE III
General Obligations

3.1. General Obligations of Lessee. Lessee agrees that, at all times from the Effective Date hereof until the termination of this Lease, Lessee shall at its sole cost and expense:

(a) obtain all necessary permits and/or governmental licenses to comply, at all times, with the terms of any Federal, state or local regulations affecting the Premises or the Facility and the use and operation thereof as a "life care" or "continuing care" community with on-site nursing care and other health facilities;

(b) during the term of this Lease, to charge entrance fees and monthly fees under residence and care agreements in amounts sufficient to allow Lessee to operate the Facility consistent with high standards of similar facilities as well as to meet all of its debt obligations and all obligations under this Lease;

(c) maintain sufficient personnel to operate the Facility consistent with the standards of similar, high quality facilities;

(d) maintain its charitable, non-profit status, and, if obtained, its status as an entity exempt from federal income taxation under Section 501(c)(3) of the Code and its non-private foundation status under Section 509 of the Code (or corresponding or successor provisions thereof);

(e) promptly notify Lessor of the institution or threat of any action, proceeding or claim affecting the Facility or the Premises;

(f) within one hundred thirty-five (135) days following the end of each fiscal year of Lessee, provide Lessor with a profit and loss statement for such fiscal year, a balance sheet of Lessee as of the end of such year and a statement of changes in financial condition for such year, including a statement as to the status of any reserve funds, certified by an independent public accountant of recognized standing, and within thirty (30) days following the end of each of the first three fiscal quarters of each fiscal year of Lessee, provide Lessor with an unaudited profit and loss statement, an unaudited balance sheet as of the end of such fiscal quarter and a statement as to the status of the reserve funds required hereunder;

(g) permit Lessor to review all of Lessee's books and records including, but not limited to, books and records which relate to reserve accounts, application of

costs and expenses, unit occupancy and resale funds with respect to the Facility, at any reasonable time upon reasonable notice;

(h) pay or cause to be paid all charges for all utility services and for telephone or other communication services used on, and other services rendered or supplied upon or in connection with, the Premises throughout the term of this Lease, and indemnify Lessor and save Lessor harmless against any liability or damages on such account;

(i) subject to Article VIII, take good care of the Improvements and the personal property on the Premises whether owned by Lessor or Lessee ("Personalty"), and the sidewalks, curbs and parking areas in or adjoining the Premises, and, subject to the provisions of this Lease elsewhere set forth, keep the same in good order and condition, and promptly at Lessee's own cost and expense, make all necessary repairs, interior and exterior, structural and non-structural, ordinary as well as extraordinary, foreseen as well as unforeseen. Notwithstanding the foregoing, with respect to any repairs necessitated by any insured loss, insurance proceeds received with respect to such loss shall be applied to such repairs. As used in this subparagraph, the term "repairs" shall include replacements and renewals and all such repairs made by Lessee shall be at least equal in quality and usefulness to the original improvements and equipment;

(j) keep and maintain all portions of the Premises in a clean and orderly condition, free of accumulation of dirt and rubbish; keep all open areas of the Premises not built upon or paved, landscaped and properly maintained as landscaped areas;

(k) promptly comply with all laws and ordinances and notices, orders, rules, regulations and requirements of all Federal, state and municipal governments and appropriate departments, commissions, boards and officers thereof, and notices, orders, rules and regulations of the National Board of Fire Underwriters, or any other body now or hereafter constituted exercising similar functions, relating to all or any part of the Premises (exterior as well as interior, foreseen or unforeseen, ordinary as well as extraordinary, structural as well as non-structural), to the fixtures and equipment thereof, to the sidewalks, curbs and parking areas in or adjoining the Premises, or to the use or manner of use of the Premises and Lessee shall likewise observe and comply with the requirements of all policies of public liability, fire and all other policies of insurance at any time in force with respect to the Premises or any part thereof and the equipment thereon;

(l) not permit any loading or unloading of commercial vehicles on the Premises other than at the loading docks;

(m) not, without on each occasion, first obtaining Lessor's prior written consent, which consent shall not be unreasonably withheld, make or permit to be made any exterior or structural alterations or additions to the Improvements or any part thereof or to any portion of the Premises; not make any alterations or additions to the Improvements except for (1) minor changes which will not reduce the value of the Improvements nor impair their structural strength, and for (2) the addition of fixtures and equipment which do not damage the Improvements;

(n) permit Lessor and the authorized representatives of Lessor to enter the Premises at reasonable times during usual business hours for the purpose of (1) inspecting the same and (2) making any necessary repairs thereto and performing any work therein that may be necessary by reason of Lessor's obligations hereunder or by reason of Lessee's default under the terms of this Lease. Nothing herein shall imply any duty upon the part of Lessor to do any such work which under any provisions of this Lease Lessee may be required to perform and the performance thereof by Lessor shall not constitute a waiver of Lessee's default in failing to perform the same;

(o) permit Lessor, during the progress of any work in the Premises, to keep and store therein all necessary materials, tools and equipment. Lessor shall not be liable for inconvenience, annoyance, disturbance, loss of business or other damage to Lessee by reason of making such repairs or the performance of such work on the Premises, or on account of bringing materials, supplies and equipment into or through the Premises during the course thereof and the obligations of Lessee under this Lease shall not thereby be affected in any manner whatsoever;

(p) give and hereby gives Lessor the right during usual business hours to enter the Premises and to exhibit the same for the purposes of sale, mortgage or other transfer;

(q) if, in connection with the obtaining, continuing, renewing or replacing of financing for which the Facility represents collateral in whole or in part, a savings or commercial bank or trust company, insurance company, savings and loan association, a welfare pension or retirement fund or system or any other institutional lender shall request reasonable modifications of this Lease as a condition of such financing or refinancing, not unreasonably withhold, condition or delay its consent thereto provided that any such modification does not materially and adversely increase its obligations or affect its rights hereunder or thereunder;

(r) except for entering into residence and care agreements, not assign, mortgage, pledge or encumber this Lease or the leasehold estate created hereby, in whole or in part, or sublet the whole or any part of the Premises, without first obtaining the written consent of Lessor, which consent may be withheld in Lessor's sole discretion. In the event of any such assignment or subletting of all or substantially

all of the Facility. Lessee shall deliver to Lessor, at the time of any such assignment or sublease, the assumption by the assignee or sublessee of all of the obligations and liabilities of Lessee hereunder, and Lessee and any guarantor or surety of Lessee shall nevertheless continue to be liable for the performance of all the terms, conditions and covenants of this Lease;

(s) not, without Lessor's prior written consent, transfer any ownership or membership rights or affiliate with any other entity;

(t) be responsible for and relieve, and hereby does relieve Lessor, from and agrees to indemnify Lessor against, all liability by reason or any injury or damage to Lessee or to any other person or to property in the Premises, whether belonging to Lessee or to any other person, whether or not such injury or damage be caused by or results from the negligence of Lessee or any other person or persons whatsoever, whether or not such event results from a condition which existed prior to the execution of this Lease and whether or not such event results in the termination of this Lease by reason of damage to or destruction of the Premises unless such injury or damage results from Lessor's gross negligence;

(u) promptly yield up, clean and neat, and in the same condition, order and repair in which they are required to be kept throughout the term hereof (ordinary wear and tear and damage from fire and other casualty excepted), the Premises and all Improvements, alterations and additions thereto, and all fixtures and equipment servicing the Improvements; and remove its signs, goods and effects and any machinery, furniture, fixtures and equipment used in the conduct of Lessee's business not servicing the Improvements, and not owned by Lessor (or substitutes or replacements thereof or therefor), and to repair any damage caused by the installation or removal thereof; and

(v) not, without Lessor's prior written consent, which consent shall not be unreasonably withheld, agree to any changes in the Management Agreement between Lessee and Life Care Services, LLC (the "Management Agreement"), execute a new Management Agreement, or obtain management services from any person or corporation other than Life Care Services, LLC.

3.2. Absolutely Net Lease. It is the intent of the parties hereto that Lessee shall bear all costs, charges and expenses associated with the Premises and the Facility.

ARTICLE IV
Insurance

4.1. Obligations of Lessee with Respect to Insurance. Lessee, at Lessee's sole cost and expense, shall maintain and keep in effect throughout the term:

(a) insurance against loss or damage to the Improvements and the Personalty upon the Premises by fire and such other casualties as may be included in the broadest form of all risk, extended coverage insurance from time to time available (including, but not necessarily limited to, coverage for damage from flood, earthquakes, back-up of sewers and drains, surface water and subsidence), in an amount at least equal to replacement cost thereof, and shall include an agreed amount endorsement to such policy; the agreed amount endorsement shall be modified each year upon agreement by Lessor and Lessee in consultation with the casualty insurer;

(b) boiler and machinery insurance coverage on a broad form comprehensive basis;

(c) business interruption insurance and expense coverage in an amount agreed upon by Lessor and Lessee on an annual basis but in an amount at least equal to the total operating expenses of the Facility for the year immediately preceding the year for which such insurance is obtained;

(d) insurance against abatement or loss of rental by reason of any of the occurrences described in the preceding subparagraph (a);

(e) all risk, extended coverage insurance against loss, damage, or destruction to all signs, trade fixtures, improvements, equipment, furniture and other installments and property installed by Lessee on the Premises;

(f) such other insurance as reasonably may be required by the holder from time to time of a mortgage or deed of trust upon fee or leasehold title to the Premises or as may be required generally by mortgage lending institutions;

(g) insurance against loss or liability in connection with bodily injury or death or property damage in or upon the Premises, under policies of general public liability insurance, with such limits as to each as may be reasonably required by Lessor from time to time but not less than Ten Million Dollars ($10,000,000) for each person or for each occurrence in respect to bodily injury or death and Two Hundred Fifty Thousand Dollars ($250,000) for each occurrence in respect to property damage; and

(h) professional liability insurance (including medical malpractice coverage) in such amounts as is reasonable and customary in the industry and such other insurance as may be reasonable and appropriate to the operation of the Facility.

4.2. Terms of Insurance Policies Purchased by Lessee.

4.2.1. The policies of insurance provided for in paragraph 4.1 shall name as the insured party Lessee, Lessor and, in accordance with the standard mortgagee endorsement, any mortgagee or other party designated by Lessor. The policies of general public liability insurance shall name Lessor and Lessee as the insured parties and shall contain a cross-liability endorsement providing each of the parties the benefit of the insurance in the event a claim is brought by one of the parties against the other.

4.2.2. All policies shall provide that they shall not be cancelable without at least thirty (30) days prior written notice to Lessor and to any mortgagee designated as aforesaid by Lessor and shall be issued by insurers of recognized responsibility licensed to do business in the State of Maryland and approved by Lessor. Lessee will provide the original and a signed duplicate copy of each of such policies, and at least ten (10) days prior to the expiration of such policy, replacements thereof, to Lessor.

4.3. Mutual Release from Liability. Each of the parties hereto hereby releases the other, to the extent of the releasing party's actual recovery under its insurance policies, from any and all liability for any loss or damage which may be inflicted upon the property of such party even if such loss or damage shall be brought about by the fault or negligence of the other party, its agents or employees; provided, however, that this release shall be effective only with respect to loss or damage occurring during such time as the appropriate policy of insurance shall contain a clause to the effect that this release shall not affect said policy or the rights of the insured to recover thereunder. If any policy does not provide for such a waiver, Lessee agrees to obtain an endorsement to the aforesaid policies covering the Premises and to all of its other insurance policies permitting such a waiver of subrogation and to pay the amount of any additional premium charged for such endorsement.

4.4. Revision of Insurance Coverage.

(a) On each anniversary of the Commencement Date, the parties shall review whether the insurance minimums stated in this Article IV provide for sound and prudent coverage in relation to liability risks as of each such date. As of each date, the parties shall mutually agree on appropriate liability insurance minimums, which agreement shall not be unreasonably withheld.

(b) Within thirty (30) days following establishment of any required adjustment, Lessee shall forward to Lessor certificates of insurance indicating that insurance in no less than the required amounts is in full force and effect.

ARTICLE V

Damage to or Destruction of the Premises and Eminent Domain

5.1. Damage by Fire or Other Casualty.

5.1.1.1. Insured Casualty. If the Premises, or any portion thereof, are damaged by fire, the elements, unavoidable accident, or other casualty which are included under insurance coverage maintained in accordance with this Lease, Lessee shall notify Lessor promptly of such event. It is understood and agreed that Lessee shall have the sole and absolute obligation to restore the Premises, or any portion thereof, in the event the Premises, or any portion thereof, are damaged by fire, the elements, unavoidable accident, or other casualty which are included under insurance coverage maintained in accordance with this Lease to the extent it receives sufficient insurance proceeds to do so.

5.1.1.2. If by reason of such occurrence, the Premises shall be rendered wholly untenantable, Lessee shall promptly cause such damage to be repaired to the extent of net insurance proceeds, unless within sixty (60) days after Lessor receives notice from Lessee of such occurrence Lessor shall give Lessee written notice that it has elected not to reconstruct the destroyed Premises in which event, this Lease and the tenancy hereby created, shall cease as of the date of such occurrence.

5.1.1.3. Anything to the contrary in the immediately preceding paragraphs of this Article notwithstanding, in case of destruction of the Premises or the Improvements or damage thereto from any cause so as to make it partially untenantable occurring during the last twenty (20) years of the term hereof, Lessor may elect to terminate this Lease by written notice served on Lessee within sixty (60) days after Lessor receives notice from Lessee of the occurrence of such damage or destruction. In the event of such termination, there shall be no right on the part of Lessee to receive any proceeds collected under any insurance policies covering such Premises or Improvements, or any part thereof, all such proceeds to be the sole property of Lessor.

5.1.1.4. Any repair or reconstruction required hereunder shall be commenced promptly and completed with due diligence, taking into account the time required for Lessor and Lessee jointly to effect a settlement with, and procure insurance proceeds from, the insurer, except for delays due to governmental regulations, scarcity of or inability to obtain labor or materials, or causes beyond Lessee's reasonable control.

5.1.2. Uninsured Casualty. If, by the terms of this Lease, insurance is not required to be carried against the risk which caused the damage, or if the risk is of a nature that it is uninsurable, or if insufficient proceeds are available, Lessor may either

repair the damage or terminate this Lease by giving Lessee within sixty (60) days after Lessor receives notice of such damage from Lessee, notice specifying the termination date, unless Lessee before the termination date agrees to pay the cost of repair and gives Lessor adequate security for the payment.

5.2. Eminent Domain. If the Premises, or any portion thereof, is threatened with a taking by any entity having the power of eminent domain, the party receiving notice thereof promptly shall notify the other of such event.

5.2.1. Termination as to Part Taken. If the Premises or any part thereof is taken or condemned for a public of quasi-public use (a sale in lieu of condemnation to be deemed a taking or condemnation), this Lease shall, as to the part taken, terminate as of the date title shall vest in the condemnor, provided that the provisions concerning the payment of awards as provided below shall continue in full force and effect. In any such event, Lessee waives all claims against Lessor and all claims against the condemning authority or party except those granted by statute to tenants concerning moving and related expenses and Lessee covenants and agrees that Lessee will make no claim by reason of the complete or partial taking of the Premises except as above provided.

5.2.2. Frustration of Purpose. (i) If there is a total taking of the Premises, or (ii) if as a result of any such taking or condemnation less than a total taking, Lessor and Lessee agree that the Facility cannot reasonably be operated as a residential life care facility, then this Lease shall terminate as of the date when Lessee is required to vacate all or the portion of the Improvements taken or the portion of the Premises taken other than Improvements.

5.2.3. Lessor's Obligation in the Event of Partial Taking. If, after exercise of eminent domain, this Lease is not terminated, Lessee shall do such work as reasonably may be necessary to restore what may remain of the Premises to tenantable condition for Lessee's uses, but shall not be required to expend more than the net award, after any required payment to any mortgagee or beneficiary under any mortgage or deed of trust, Lessee reasonably expects to be available for restoration. Any repair or restoration shall be commenced within four (4) weeks after the date when Lessee is required to vacate the portion taken and completed with due diligence, except for delays due to governmental regulation, inability to obtain labor and materials, or other causes beyond Lessor's reasonable control.

5.3. Lender Requirements. Notwithstanding anything to the contrary contained in this Article V, all rights of Lessor and Lessee in connection with any casualty or condemnation shall be subject in all respects to the provisions of that certain deed of trust from Lessor and Lessee to Pamela S. Hazelip and David L. Williams, Trustees securing a loan made with the proceeds of Howard County, Maryland

Retirement Community Revenue Bonds (Vantage House Facility), Series 2000A, B and C, in the aggregate principal amount of $26,410,000 dated October 1, 2000 ("Deed of Trust"). All references herein to the Deed of Trust shall include, without limitation, all documents and instruments executed in connection with the financing secured by the Deed of Trust.

ARTICLE VI
Default

6.1. Default by Lessee. If Lessee shall (a) abandon the Premises, or (b) become insolvent, bankrupt, or make an assignment for the benefit of creditors, or (c) be levied upon or sold out by sheriff's or marshal's or constable's sale, or (d) have or suffer a receiver for Lessee to be appointed, Lessee shall be in default under this Lease, or (e) in any respect violate any of the terms, conditions or covenants herein.

6.2. Lessor's Remedies Upon Default by Lessee. In the event of a default under this Lease by Lessee, Lessor shall be entitled to all remedies it may have at law and in equity including, but not limited to, those set forth below.

6.2.1. Rights of Reentry and Specific Performance. Lessor may re-enter and repossess the Premises, together with all Improvements and additions thereto, or pursue any remedy permitted by law or equity for the enforcement of the provisions hereof.

6.2.2. Right to Terminate Lease. Lessor may give to Lessee at any time after the occurrence of the default, written notice of Lessor's election to terminate this Lease on a date to be specified in such notice, not less than ten (10) days after the giving thereof, and upon the date specified in such notice, this Lease and the terms thereof shall (except for the continued liability of Lessee as hereinafter provided) expire and come to an end as fully and completely as if the date specified in such notice were the date definitely fixed in this Lease for the expiration of the term hereof, and Lessee shall quit and surrender the Premises, on or before the said date, to Lessor, without cost or charge to Lessor. Lessor may elect to continue in occupancy the residents of the Facility, collecting monthly fees in exchange for providing services under the residence and care agreements, or, at Lessor's option, may require Lessee to terminate occupancy by all of such residents, if allowed by law.

6.2.3. Right to Relet. In the event this Lease shall be terminated as herein provided, or in case of termination of Lessee's possession by re-entry, summary dispossess proceedings or any other method, Lessor may, at Lessor's option, as an additional or alternative remedy, relet the Premises or any part or parts thereof for the account of Lessee for the remainder of the period until the time when this Lease would have expired but for such prior expiration on default or for such re-entry and termination, or for any portion of such period, or, at Lessor's option, relet the Premises

or any part or parts thereof for a period extending beyond the date when this Lease could have expired but for such prior expiration on default or for such re-entry and termination, and deem that portion of the period within the term originally specified for the expiration hereof as a rental for the account of Lessee.

6.2.3.1. Application of Proceeds of Reletting. In the event that Lessor relets the Premises as provided in subparagraph 6.2.3 hereof, any rent the Lessor receives shall be applied first to the payment of such expenses of every kind and nature as Lessor may incur or assume in recovering possession of the Premises and in connection with the reletting of the Premises and then to the fulfillment of the covenants and agreements of Lessee hereunder, and Lessee shall remain liable as herein provided.

6.2.3.2 No Obligation to Relet. There shall be no obligation on the part of Lessor to relet, nor any liability on its part for failure to relet or for failure to collect the rent in case the Premises are relet and Lessee's liability shall not be diminished or affected by such failure to relet, failure to collect the rent, or the giving of rental or other concessions in the event of re-letting as aforesaid.

6.2.4. Lessor's Right to Cure Lessee's Defaults. Lessor may (but shall not be obligated to do so) in addition to any other rights it may have in law or equity and after written notice to Lessee, except in case of emergency, cure any default by Lessee on behalf of Lessee, and Lessee shall reimburse Lessor for any sums paid or costs incurred by Lessor in curing such default, including interest at the rate equal to two percent (2%) per annum above the announced prime rate of interest at First Union Bank, Baltimore, Maryland (or any successor thereto) as is in effect from time-to-time, on all sums advanced by Lessor as aforesaid, which sums and costs together with interest thereon shall be payable upon demand.

6.3 Time for Exercise of Remedies Upon Default.

6.3.1. Grace Period. Notwithstanding anything hereinabove stated, other than with respect to the obtaining and maintaining of any insurance required hereunder, it is understood and agreed that neither party hereto will exercise any right or remedy provided for in the Lease or allowed by law because of any default of the other, unless such party shall have first given written notice thereof to the other, and the other, within a period of ten (10) days thereafter, shall have failed to pay the sum or sums due if the default consists of the failure to pay money, or if the default consists of something other than the payment of money, shall have failed, within thirty (30) days thereafter to begin and actively and diligently in good faith to proceed with the correction of the default until it shall be fully corrected; provided, however, that no such notice from Lessor shall be required more than twice in any one year.

6.3.2. Immediate Exercise of Rights. Anything in subparagraph 6.3.1 to the contrary notwithstanding, Lessor shall not be required to give any notice or allow any part of such grace period if Lessee shall have removed from or shall be in the course of removing from the Premises or if a petition in bankruptcy or for reorganization shall have been filed by or against Lessee, resulting in an adjudication of bankruptcy or for reorganization or if a receiver or trustee is appointed for Lessee and such appointment and such receivership or trusteeship is not terminated within sixty (60) days or Lessee makes an assignment for the benefit of creditors or if Lessee is levied upon and is about to be sold out upon the Premises by any sheriff, marshal or constable.

6.4. Default by Lessor. In the event of any default by the Lessor, Lessee shall have all rights and remedies available to it at law or in equity.

ARTICLE VII
Termination

7.1. Expiration. This Lease shall, unless sooner terminated pursuant to the provisions hereof, expire absolutely on November 30, 2099 without the requirement of any notice from Lessor.

7.2. Lessee's Obligation Upon Termination.

7.2.1. Obligation. In the event of termination of this Lease as herein provided, or of termination of Lessee's possession by re-entry, summary dispossess proceedings or any other method, whether or not the Premises be relet, Lessee shall, until the time when this Lease would have expired but for such prior expiration or for such re-entry, summary dispossess proceedings or termination, continue and remain liable for the rent herein reserved, less the avails of reletting (after deduction of all expenses of recovery of possession and reletting), if any, and the same shall be due and payable by Lessee to Lessor on the several days above specified for the payment thereof; that it, upon each of such days Lessee shall pay to Lessor the amount of deficiency then existing. Upon such expiration, termination or re-entry as aforesaid, neither Lessee nor Lessee's creditors or representatives shall thereafter have any right, legal or equitable, in or to the Premises or any part thereof, or in or to the repossession of same, or in or to this Lease; and Lessee hereby waives all right of redemption which is or may hereafter be provided by law. The words "re-enter" and "re-entry" as used in this Lease are not restricted to their technical legal meaning.

7.2.1.1. Any mention in this Article VII of the rent or rental herein reserved after the termination of this Lease as in this paragraph provided, or of termination of Lessee's possession by re-entry, summary dispossess proceedings or any other method as herein provided shall be deemed to refer to the annual rent and such additional sums as Lessee shall be obligated to pay to Lessor or to any third

person under any of the terms, covenants and conditions of this Lease, whether or not designated or indicated herein to be payable as additional rent.

7.2.1.2. Any action taken by Lessor under this Lease shall not operate as a waiver of any right which Lessor would otherwise have against Lessee for rent hereby reserved or otherwise, and Lessee shall remain responsible to Lessor for any loss and/or damage suffered by Lessor by reason of Lessee's default or breach.

7.2.2. Transfer of Licenses and Permits. If this Lease is terminated other than by expiration for any reason including, but not limited to, default by Lessee, Lessee will assign or otherwise transfer to Lessor, or such other person(s) as Lessor shall designate, at Lessor's election, to the full extent permitted by then applicable law, all rights to or in any and all CONs, licenses, certificates, or other regulatory permits required for operation of the Facility, and any and all rights with respect to any entrance fees if Lessor elects to continue the residents in occupancy hereunder. Lessee further agrees to cooperate fully with Lessor in any manner necessary to obtain all governmental consents required to transfer the CONs, licenses, certificates and permits (or the issuance of new CONs, licenses, certificates or permits in substitution therefor) including, but not limited to, participation in any administrative proceedings necessary to accomplish the same.

7.2.3. Operation of Premises. If this Lease is terminated by reason of default by Lessee and Lessor elects to operate the Premises with another lessee, Lessee shall be obligated, at Lessor's option, to continue operating the Premises until such time as Lessor is able, making reasonable efforts, to replace Lessee.

ARTICLE VIII
Miscellaneous

8.1. Subordination. This Lease and all of the rights of Lessee and Lessor hereunder and all rights of Lessee's residents under residence and care agreements shall be and hereby are declared to be, now and at all times hereafter, subject and subordinate to any mortgage or deed of trust, including without limitation, the Deed of Trust, as well as the rights of the mortgagee or beneficiary under any mortgage or deed of trust, including without limitation, the Deed of Trust, whether now or hereafter created, covering in whole or in part the Premises and securing a loan used, in whole or in part, to finance or refinance the Land and/or the construction and operation of the Facility.

8.2. Improvements, Repairs and Alterations. All improvements, repairs, alterations and all other property attached to or used in connection with the Premises or any part thereof made or installed on the Premises by or on behalf of Lessee shall immediately upon completion or installation thereof be and become the property of

Lessor without payment therefor by Lessor and shall be surrendered to Lessor upon the expiration or earlier termination of the term of this Lease, except that any machinery, furniture, equipment or fixtures installed by Lessee at Lessee's cost and expense and used in the conduct of Lessee's business and not to service the Facility particularly shall remain Lessee's property and shall be removed by Lessee at the termination of this Lease provided that Lessee shall fully and promptly restore any damage to the Premises occasioned by the installation or removal thereof.

8.3. Latent Defects. If, during the term of this Lease, Lessee identifies any defects in the material or workmanship of or in the Facility, Lessee shall have no cause of action against Lessor whatsoever.

8.4. No Waivers. The failure of Lessor to insist on any one or more instances upon the performance of any of the covenants or conditions of this Lease or to exercise any right or privilege herein contained shall not be construed as thereafter waiving or relinquishing any such covenants, conditions, rights or privileges and the same shall continue and remain in full force and effect, and waiver of one default or right shall not constitute waiver of any other default.

8.5. Notices. All notices required or permitted hereunder from either of the parties to the other shall be in writing and either hand delivered or sent by certified mail, return receipt requested, postage prepaid, addressed as set forth below, and shall be deemed to be received on the date of receipt (if hand delivered) or the date of execution of the return receipt or the date on which the postal authorities first attempted delivery thereof and such notice is undeliverable or refused. Notices to Lessee shall be addressed to

Columbia Vantage House Corporation
5400 Vantage Point Road
Columbia, Maryland 21044
Attn: President

with a copy to

Herman Rosenthal, Esq.
Whiteford, Taylor & Preston L.L.P.
7 St. Paul Street
Baltimore, MD 21202
Facsimile number (410) 752-7092

Notices to Lessor shall be addressed to

Vantage House LLC

5400 Vantage Point Road
Columbia, Maryland 21044
Attn: President, Columbia Vantage House Corporation

with a copy to

Herman Rosenthal, Esq.
Whiteford, Taylor & Preston L.L.P.
7 St. Paul Street
Baltimore, MD 21202
Facsimile number (410) 752-7092

and another copy to any mortgagee or trustee under a deed of trust, designated by Lessor. Either party may at any time, in the manner set forth for giving notices to the other, set forth a different address to which notice to it shall be sent.

8.6. Memorandum of Lease; Estoppel Certificate. It is understood and agreed that the parties will execute and acknowledge simultaneously with the execution of this Lease a short form thereof or memorandum of lease for recording purposes, if such is request by either party. The costs of recording such memorandum shall be borne by the party requesting such recordation.

The parties agree at any time and from time-to-time within ten (10) days after written request from the other party, to execute, acknowledge and deliver to the other party a written instrument in recordable form certifying that this Lease is unmodified and in full force and effect (or if there have been modifications, that the same is in full force and effect as modified and stating the modifications); that Lessee has accepted possession of the Premises and the date on which the term of the Lease commenced; stating whether or not to the best knowledge of the signer of such certificate Lessor or Lessee is in default in the performance of any covenant, agreement or condition contained in this Lease, and if so, specifying each such default of which the signers may have knowledge, and stating that it is understood that such instrument may be relied upon by any prospective purchaser of the fee or any mortgagee thereof or any assignee of Lessor's interest in this Lease or of any mortgage or deed of trust upon the fee of the Premises, or any part thereof.

8.7. Definition of "Lessor". The word "Lessor" is used herein to include the Lessor named above as well as its successor and assigns, and any other subsequent owner of the Premises, as well as the heirs, personal representatives or successors and assigns of any such subsequent owner, each of whom shall have the same rights, remedies, powers, authorities and privileges as it would have had had it originally signed this Lease as Lessor, but any such person, whether or not named herein, shall

have no liability hereunder after it ceases to hold title to the Premises, except for obligations which may have theretofore accrued.

8.8. Definition of "Lessee". The word "Lessee" is used herein to include the Lessee named above as well as its successors and assigns, each of which shall be under the same obligations, liabilities and disabilities and have only such rights, privileges and powers as it would have possessed had it originally signed this Lease as Lessee. However, no such rights, privileges or powers shall inure to the benefit of any assignee of Lessee, immediate or remote, unless the assignment to such assignee is permitted of right hereunder or has been approved in writing by Lessor.

8.9. Amendment of Agreement. No subsequent alteration, amendment, change or addition to this Lease shall be binding upon Lessor or Lessee unless reduced to writing and signed by them and approved by the holder of any mortgage or deed of trust on the Premises, if a mortgage or deed of trust had been given.

8.10. Captions. The captions of this Lease are for convenience only and are not a part of this Lease and do not in any way limit or amplify the terms and provisions of this Lease.

8.11. Independent Contractor. Each of the parties hereto is an independent contractor with, and not an agent for, the other, and no partnership or joint venture shall be deemed to exist by reason of this Lease.

8.12. Consents and Approvals. Any consent or approval called for under this Lease by either party shall not be unreasonably withheld (unless otherwise specifically provided). Lessee shall, at Lessor's request, designate a duly authorized representative of Lessee on whom Lessor is entitled to rely to act on Lessee's behalf.

8.13. Severability. In the event that any one or more of the provisions of this Lease shall be declared invalid by a final and unappealable order or decree or any court of competent jurisdiction, this Lease shall be construed as if such provision had not been included; provided that if such invalidity shall nullify the fundamental basis of this Lease or the intent thereof, then this Lease shall terminate.

8.14. Choice of Law. This Lease shall be governed by and construed in accordance with the Laws of the State of Maryland.

[Signatures on following page]

IN WITNESS WHEREOF, the parties have executed this Lease under seal, with the intent that this Lease be a sealed instrument, the day and year first above-written.

WITNESS:

LESSOR

VANTAGE HOUSE LLC
By: Columbia Vantage House Corporation,
Sole Member

By: _____ (SEAL)
Name: Richard M. McCauley
Title: President

WITNESS:

LESSEE

COLUMBIA VANTAGE HOUSE CORPORATION

By: _____ (SEAL)
Name: Richard M. McCauley
Title: President

STATE OF MARYLAND, ~~COUNTY~~ City OF Baltimore, TO WIT:

I HEREBY CERTIFY, that on this 15th day of November, 2000, before me, the subscriber, a Notary Public of the State of Maryland, personally appeared RICHARD M. MCCAULEY, who acknowledged himself to be the President of COLUMBIA VANTAGE HOUSE CORPORATION, and he acknowledged that he executed the foregoing on behalf of the said Corporation for the purposes therein contained and he acknowledged the same to be the lawful act and deed of the aforesaid Corporation.

AS WITNESS my hand and Notarial Seal the day and year first above written.

_____
Notary Public

DEBORAH J. HOOPER NOTARY PUBLIC ANNE ARUNDEL CO. MD.

My Commission expires: 7/27/02

STATE OF MARYLAND, ~~COUNTY~~ City OF Baltimore, TO WIT:

I HEREBY CERTIFY, that on this 15th day of November, 2000, before me, the subscriber, a Notary Public of the State of Maryland, personally appeared RICHARD M. MCCAULEY , who acknowledged himself to be the President of COLUMBIA VANTAGE HOUSE CORPORATION, Sole Member of VANTAGE HOUSE LLC, and (s)he acknowledged that he executed the foregoing on behalf of the said limited liability corporation for the purposes therein contained and (s)he acknowledged the same to be the lawful act and deed of the aforesaid limited liability corporation.

AS WITNESS my hand and Notarial Seal the day and year first above written.

Deborah J. Hooper
Notary Public

DEBORAH I. HOOPER NOTARY PUBLIC ANNE ARUNDEL CO., MD.

My commission expires: 7/27/02

EXHIBIT A

LEGAL DESCRIPTION

BEING KNOWN AND DESIGNATED as Parcel F-2 as shown on plat entitled "Columbia Town Center, Section 7, Area 7, Parcel F-2 and Section 7, Area 9, Lot 1, A Resubdivision of Parcel F-1, Section 7, Area 7, Sheet 1 of 1", which plat is recorded among the Land Records of Howard County as Plat No. 3912.

TOGETHER with Deed and agreement of Easement dated August 26, 1985 and recorded among the Land Records of Howard County, Maryland in Liber 1378, folio 652, between Columbia Park and Recreation Association and Roc-Vantage Corporation.

TOGETHER with Deed of Easement and Agreement dated August 14, 1985 and recorded among the land Records of Howard County, Maryland in Liber 1378, folio 580, between Roc-Vantage Associates and American National Red Cross.

TOGETHER with Deed and Agreement of Easement dated August 23, 1985 and recorded among the Land Records of Howard County, Maryland in Liber 1378, folio 659, between The Howard Research and Development Corporation and Roc-Vantage Associates.

MEMORANDUM OF LEASE

DATED as of October 1, 2000, for reference purposes, but effective as of the 16th day of November, 2000 ("Effective Date")

BY AND BETWEEN

VANTAGE HOUSE LLC, a Maryland limited liability company ("Lessor"), having its office at 5400 Vantage Point Road, Columbia, Maryland 21044, Attn: President, Columbia Vantage House Corporation

AND

COLUMBIA VANTAGE HOUSE CORPORATION., a Maryland corporation ("Lessee"), having its offices at 5400 Vantage Point Road, Columbia, Maryland 21044, Attn: President.

WITNESSETH:

WHEREAS, the Lessor and Lessee have entered into a certain Lease Agreement (hereinafter called the "Lease"); and

NOW, THEREFORE, Lessor and Lessee hereby set forth the following information with respect to the Lease:

1. The name of the Lessor is Vantage House LLC.

2. The name of the Lessee is Columbia Vantage House Corporation.

3. The addresses set forth in the Lease as addresses of the parties are:

Lessor: 5400 Vantage Point Road
Columbia, Maryland 21044
Attn: President, Columbia Vantage House Corporation

Lessee: 5400 Vantage Point Road
Columbia, Maryland 21044
Attn: President

4. The description of the Premises as set forth in the Lease is as set forth in Exhibit A attached hereto.

5. Annual Rent. Lessee agrees to pay to Lessor, throughout the term of the Lease, annual rent in the sum of One Dollar ($1.00), such amount being the actual and

total consideration to be paid, there being no other money or other consideration paid or to be paid by Lessee to Lessor as rent or other consideration hereunder.

6. The term of the Lease commenced on the date hereof, runs for a period of ninety-nine (99) years, plus approximately fifteen (15) days, and will expire on November 30, 2099.

7. Lessor and Lessee are affiliated parties. It is their intent that this Lease shall only continue in full force and effect so long as Lessor owns the Premises, Lessor and Lessee are both in existence, and Lessor and Lessee remain affiliated parties. Therefore, in the event any such condition is at any time not satisfied, this Lease shall automatically terminate, unless both Lessor and Lessee agree otherwise. In the event of any such termination, all liability that either Lessor or Lessee had as of such date or may have had in the future shall terminate together with this Lease.

8. The Lessee has not been granted a right of purchase or of refusal on the Premises or any part thereof.

9. This Memorandum of Lease is prepared, signed and acknowledged solely for recording purposes, and is in no way intended to change, alter, modify, amend or in any other way affect the rights, duties and obligations of Lessor and Lessee pursuant to the Lease. It is specifically understood and agreed between the parties that each has rights, duties and obligations pursuant to the Lease which are not expressly contained herein but are included herein by reference. Notwithstanding anything to the contrary contained in this Memorandum of Lease, in the event any provisions of this Memorandum of Lease are inconsistent with any of the provisions of the Lease, the terms of the Lease shall prevail.

10. Notice is hereby given that Lessor shall not be liable for any labor or materials furnished or to be furnished to Lessee upon credit, and that no mechanics' or other lien for any such labor or materials shall attach to or affect the estate or interest of lessor in and to the premises.

[SIGNATURES ON FOLLOWING PAGE]

11. Lessee hereby covenants and agrees to take all actions necessary, at Lessee's sole cost and expense, to terminate and release this Memorandum of Lease within thirty (30) days after the date the term of this Lease expires or is terminated.

WITNESS the due execution hereof.

WITNESS:

LESSOR

VANTAGE HOUSE LLC
By: Columbia Vantage House Corporation, Sole Member

By: _____ (SEAL)
Name: Richard M. McCauley
Title: President

WITNESS:

LESSEE

COLUMBIA VANTAGE HOUSE CORPORATION

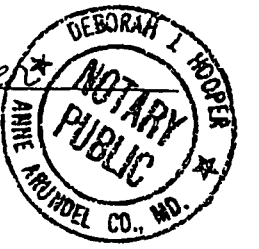
By: _____ (SEAL)
Name: Richard M. McCauley
Title: President

STATE OF MARYLAND, ~~COUNTY~~ City OF Baltimore, TO WIT:

I HEREBY CERTIFY, that on this 15th day of November, 2000, before me, the subscriber, a Notary Public of the State of Maryland, personally appeared RICHARD M. MCCAULEY, who acknowledged himself to be the President of COLUMBIA VANTAGE HOUSE CORPORATION, and he acknowledged that he executed the foregoing on behalf of the said Corporation for the purposes therein contained and he acknowledged the same to be the lawful act and deed of the aforesaid Corporation.

AS WITNESS my hand and Notarial Seal the day and year first above written.

Deborah J. Hooper
Notary Public



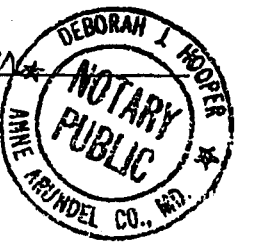
My Commission expires: 7/27/02

STATE OF MARYLAND, ~~COUNTY~~ City OF Baltimore, TO WIT:

I HEREBY CERTIFY, that on this 15th day of November, 2000, before me, the subscriber, a Notary Public of the State of Maryland, personally appeared RICHARD M. MCCAULEY , who acknowledged himself to be the President of COLUMBIA VANTAGE HOUSE CORPORATION, Sole Member of VANTAGE HOUSE LLC, and (s)he acknowledged that he executed the foregoing on behalf of the said limited liability corporation for the purposes therein contained and (s)he acknowledged the same to be the lawful act and deed of the aforesaid limited liability corporation.

AS WITNESS my hand and Notarial Seal the day and year first above written.

Deborah J. Hooper
Notary Public



My commission expires: 7/27/02

I hereby certify that this instrument was prepared by the undersigned, an attorney admitted to practice before the Court of Appeals of Maryland.

Gail M. Stern

EXHIBIT A

LEGAL DESCRIPTION

BEING KNOWN AND DESIGNATED as Parcel F-2 as shown on plat entitled "Columbia Town Center, Section 7, Area 7, Parcel F-2 and Section 7, Area 9, Lot 1, A Resubdivision of Parcel F-1, Section 7, Area 7, Sheet 1 of 1", which plat is recorded among the Land Records of Howard County as Plat No. 3912.

TOGETHER with Deed and Agreement of Easement dated August 26, 1985 and recorded among the Land Records of Howard County, Maryland in Liber 1378, folio 652, between Columbia Park and Recreation Association and Roc-Vantage Corporation.

TOGETHER with Deed of Easement and Agreement dated August 14, 1985 and recorded among the Land Records of Howard County, Maryland in Liber 1378, folio 580, between Roc-Vantage Associates and American National Red Cross.

TOGETHER with Deed and Agreement of Easement dated August 23, 1985 and recorded among the Land Records of Howard County, Maryland in Liber 1378, folio 659, between The Howard Research and Development Corporation and Roc-Vantage Associates.

AMENDMENT

THIS AMENDMENT (the "Amendment") is made as of December 1, 2002, by and between **VANTAGE HOUSE LLC**, a Maryland limited liability company ("Lessor"), and **COLUMBIA VANTAGE HOUSE CORPORATION**, a Maryland corporation ("Lessee").

RECITALS

Pursuant to a Lease Agreement dated as of October 1, 2000 (the "Lease"), Lessee let from Lessor a life care or continuing care community located at 5400 Vantage Point Road, Columbia, Maryland ("Facility"), as more specifically described in the Lease, a copy of which is attached hereto as **Exhibit A.**

Lessor and Lessee are entering into financing to replace the current financing for the Facility. As the Lease currently refers specifically to the current financing, Lessee and Lessor desire to amend certain terms and conditions as set forth below.

THEREFORE, in consideration of the mutual promises contained in this Amendment, the parties agree as follows:

SECTION 1 - CONSTRUCTION

This Amendment shall be construed in conjunction with the Lease and, except as amended by this instrument, all of the terms, covenants, and conditions of the Lease shall remain in full force and effect and are ratified and confirmed by this instrument.

SECTION 2 - DEFINED TERMS

All terms used in this Amendment shall have the meanings ascribed to them in the Lease unless otherwise defined in this instrument.

SECTION 3 – NEW PROVISIONS

Section 5.3 of the Lease is deleted and replaced in its entirety as follows:

"5.3. Lender Requirements. Notwithstanding anything to the contrary contained in this Article V, all rights of Lessor and Lessee in connection with any casualty or condemnation shall be subject in all respects to the provisions of any recorded deed of trust encumbering the

Facility and securing financing facilities to Lessor, Lessee, or both, existing now or in the future, including without limitation that certain deed of trust from Lessor and Lessee to Jody Staszeski and Dana Friedman, as individual trustees, securing the Borrower's Letter of Credit Obligations (as defined in such deed of trust) associated with certain Howard County, Maryland Variable Rate Demand/Fixed Rate Refunding Revenue Bonds (Vantage House Facility), Series 2002A and Howard County, Maryland Variable Rate Demand,/Fixed Rate Revenue Bonds (Vantage House Facility), Series 2002B, dated as of December 1, 2002 (the "Deed of Trust"). All references to the Deed of Trust in the Lease shall include, without limitation, all documents and instruments executed in connection with the financing secured by the Deed of Trust."

All other terms of the Lease shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be duly executed under seal and delivered as of the day and year first above written.

LESSOR:

WITNESS/ATTEST:

VANTAGE HOUSE LLC
By: Columbia Vantage House Corporation,
Its sole member

By: _____(SEAL)
Richard G. McCauley, President

LESSEE:

WITNESS/ATTEST:

COLUMBIA VANTAGE HOUSE CORPORATION

By: _____(SEAL)
Richard G. McCauley, President

1462207v4

SECOND AMENDMENT

THIS SECOND AMENDMENT (this "***Amendment***") is made as of April 1, 2007, by and between **VANTAGE HOUSE LLC**, a Maryland limited liability company ("***Lessor***"), and **COLUMBIA VANTAGE HOUSE CORPORATION**, a Maryland corporation ("***Lessee***").

RECITALS

Pursuant to a Lease Agreement dated as of October 1, 2000, as amended by an Amendment dated as of December 1, 2002 (as amended, the "***Lease***"), Lessee let from Lessor a life care or continuing care retirement community located at 5400 Vantage Point Road, Columbia, Maryland (the "***Facility***"), as more specifically described in the Lease.

Lessor and Lessee are entering into financing to replace the current financing for the Facility. As the Lease currently refers specifically to the current financing, Lessee and Lessor desire to amend certain terms and conditions as set forth below.

THEREFORE, in consideration of the mutual promises contained in this Amendment, the parties agree as follows:

SECTION 1 - CONSTRUCTION

This Amendment shall be construed in conjunction with the Lease and, except as amended by this instrument, all of the terms, covenants, and conditions of the Lease shall remain in full force and effect and are ratified and confirmed by this instrument.

SECTION 2 - DEFINED TERMS

All terms used in this Amendment shall have the meanings ascribed to them in the Lease unless otherwise defined in this instrument.

SECTION 3 – NEW PROVISIONS

Section 5.3 of the Lease is deleted and replaced in its entirety as follows:

"5.3. Lender Requirements. Notwithstanding anything to the contrary contained in this Article V, all rights of Lessor and Lessee in connection with any casualty or condemnation shall

be subject in all respects to the provisions of any recorded deed of trust encumbering the Facility and securing financing facilities to Lessor, Lessee, or both, existing now or in the future, including without limitation that certain deed of trust from Lessor and Lessee to Naresh S. Bhangoo and David J. O'Brien, as individual trustees, securing the "Corporation's Bond Obligations" (as defined in such deed of trust) associated with certain Howard County, Maryland Retirement Community Refunding Revenue Bonds (Vantage House Facility), Series 2007A and Howard County, Maryland Retirement Community Refunding Revenue Bonds (Vantage House Facility), Series 2007B, dated as of April 1, 2007 (the "***Deed of Trust***"). All references to the Deed of Trust in the Lease shall include, without limitation, all documents and instruments executed in connection with the financing secured by the Deed of Trust."

All other terms of the Lease shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be duly executed under seal and delivered as of the day and year first above written.

LESSOR:

WITNESS/ATTEST:

VANTAGE HOUSE LLC
By: Columbia Vantage House Corporation,
Its sole member

Amy C. Harmon

By: _____(SEAL)
Richard L. Vogel, Jr., President

LESSEE:

WITNESS/ATTEST:

COLUMBIA VANTAGE HOUSE CORPORATION

Amy C. Harmon

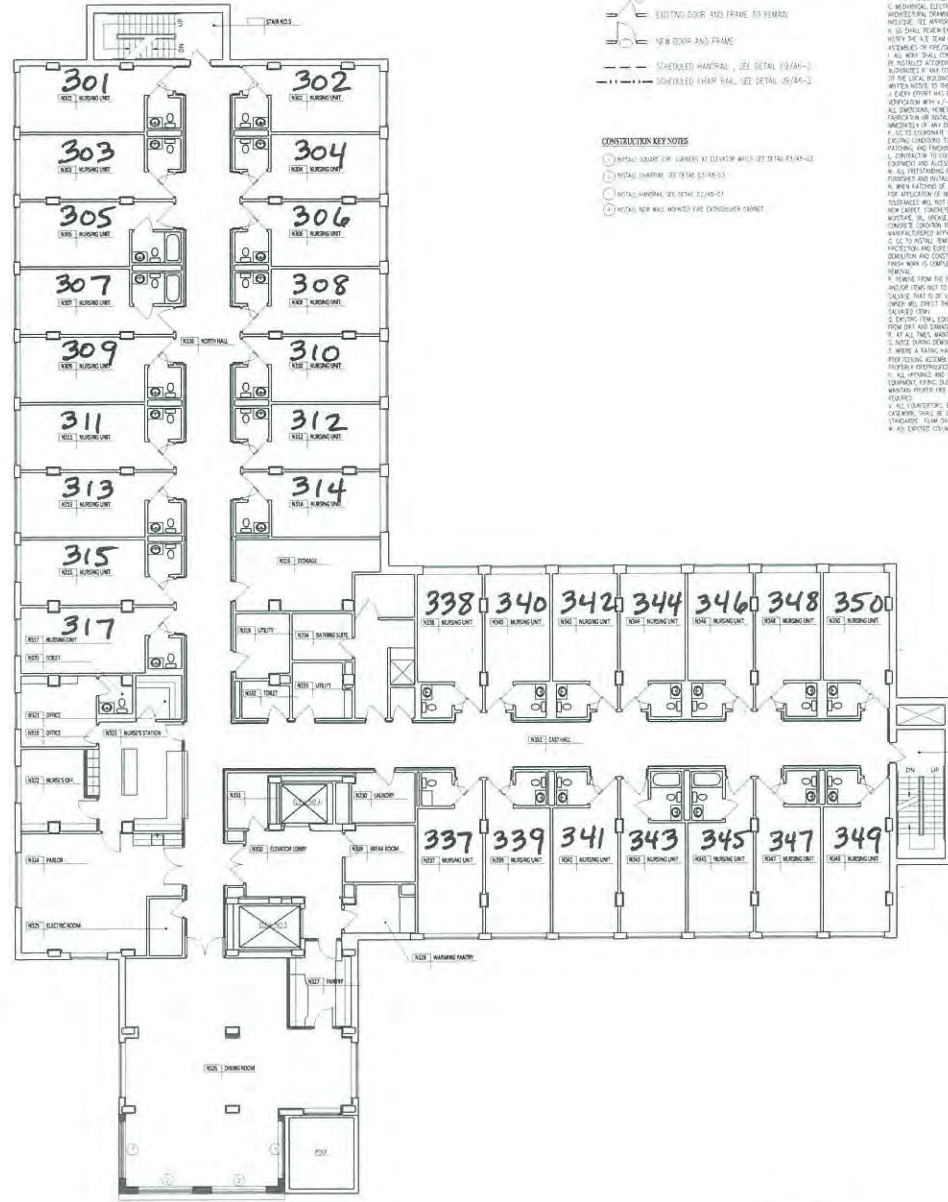
By: _____(SEAL)
Richard L. Vogel, Jr., President

EXHIBIT 2

VANTAGE HOUSE RENOVATION
VANTAGE POINT ROAD
COLUMBIA, MARYLAND

NEW WORK LEGEND

CONSTRUCTION KEY NOTES



Health Center - 3rd Floor
Skilled Nursing

THIRD FLOOR PLAN - NURSING TOWER

KEY PLAN

M9

THIRD FLOOR PLAN

A1-03

ALU TOWER

EXHIBIT 3

SENIOR LIVING COMMUNITIES MANAGED
BY LIFE CARE SERVICES LLC
AS OF 4/29/2025

Alabama, Birmingham – Galleria Woods
Alabama, Hoover – Danberry at Inverness
Arizona, Chandler – Clarendale of Chandler
Arizona, Fountain Hills – Fountain View Village
Arizona, Phoenix – Clarendale of Arcadia
Arizona, Phoenix – Sagewood
Arizona, Tempe (Phoenix) – Friendship Village of Tempe
California, Cupertino – Forum at Rancho San Antonio, The
California, Palo Alto – Moldaw Residences
California, San Diego – Casa de las Campanas
California, San Rafael – Aldersly
California, Santa Rosa – Arbol Residences of Santa Rosa
California, Santa Rosa – Oakmont Gardens
Connecticut, Essex – Essex Meadows
Connecticut, Mystic – StoneRidge
Connecticut, Southbury – Pomperaug Woods
Delaware, Newark – Millcroft Living
Delaware, Wilmington – Foulk Living
Delaware, Wilmington – Shipley Living
Florida, Aventura – Sterling Aventura
Florida, Bradenton – Freedom Village of Bradenton
Florida, Celebration – Windsor at Celebration
Florida, Clearwater – Regency Oaks
Florida, Hollywood – Presidential Place
Florida, Jacksonville – Cypress Village
Florida, Leesburg – Lake Port Square
Florida, Naples – The Glenview at Pelican Bay
Florida, Naples – The Arlington of Naples
Florida, Palm City – Sandhill Cove
Florida, Port Charlotte – South Port Square
Florida, Seminole – Freedom Square of Seminole
Florida, Seminole – Lake Seminole Square
Florida, Sun City Center – Freedom Plaza
Florida, The Villages – Freedom Point at The Villages
Georgia, Evans – Brandon Wilde
Georgia, Savannah – Marshes of Skidaway Island, The
Illinois, Addison – Clarendale of Addison
Illinois, Algonquin – Clarendale of Algonquin
Illinois, Bartlett – The Oaks at Bartlett
Illinois, Chicago – Clare, The
Illinois, Chicago – Clarendale Six Corners
Illinois, Godfrey – Asbury Village
Illinois, Lincolnshire – Sedgebrook
Illinois, Mokena – Clarendale of Mokena
Illinois, Naperville – Monarch Landing
Illinois, Wheaton – Wyndemere

Indiana, Carmel – Rose Senior Living – Carmel
Indiana, Greenwood (Indianapolis) – Greenwood Village South
Indiana, Indianapolis – Marquette
Indiana, West Lafayette – Westminster Village West Lafayette
Iowa, Ames – Green Hills Community
Iowa, Cedar Rapids – Cottage Grove Place
Kansas, Atchison – Dooley Center
Kentucky, Lexington – Richmond Place Senior Living
Maryland, Columbia – Residences at Vantage Point
Maryland, Timonium – Mercy Ridge
Maryland, Towson (Baltimore) – Blakehurst
Massachusetts, Woburn – The Delaney at The Vale
Michigan, Ann Arbor – Clarendale Ann Arbor
Michigan, Auburn Hills – The Avalon of Auburn Hills
Michigan, Battle Creek – NorthPointe Woods
Michigan, Bloomfield Township – The Avalon of Bloomfield Township
Michigan, Clinton Township – Rose Senior Living – Clinton Township
Michigan, East Lansing – Burcham Hills
Michigan, Holland – Freedom Village
Michigan, Kalamazoo – Friendship Village
Michigan, Novi – Rose Senior Living at Providence Park
Michigan, Commerce Township – The Avalon of Commerce Township
Minnesota, Buffalo – Havenwood of Buffalo
Minnesota, Burnsville – Havenwood of Burnsville
Minnesota, Maple Grove – Havenwood of Maple Grove
Minnesota, Minnetonka – Havenwood of Minnetonka
Minnesota, Richfield – Havenwood of Richfield
Minnesota, Rochester – Charter House
Minnesota, Plymouth – Trillium Woods
Minnesota, Vadnais Heights – Gable Pines
Missouri, St. Peters – Clarendale of St. Peters
New Jersey, Bridgewater – Delaney of Bridgewater, The
New Jersey, Bridgewater – Laurel Circle
New Jersey, Burlington – Masonic Village at Burlington
New Jersey, Florham Park – The Delaney at The Green
New York, Rye Brook – Broadview Senior Living at Purchase College
New York, Staten Island – Brielle at Seaview, The
North Carolina, Chapel Hill – Cedars of Chapel Hill, The
North Carolina, Charlotte – Cypress of Charlotte, The
North Carolina, Durham – Croasdaile Village
North Carolina, Greensboro – WhiteStone
North Carolina, Greenville – Cypress Glen
North Carolina, Lumberton – Wesley Pines
North Carolina, Raleigh – Cypress of Raleigh, The
North Carolina, Wilmington – Porters Neck Village
Ohio, Avon – Rose Senior Living – Avon
Ohio, Beachwood – Rose Senior Living – Beachwood
Ohio, Lewis Center – The Avalon of Lewis Center
Ohio, New Albany – The Avalon of New Albany
Oklahoma, Bartlesville – Green Country Village
Oregon, Dallas – Dallas Retirement Village

Oregon, Salem – Capital Manor
Pennsylvania, Coatesville – Freedom Village at Brandywine
Pennsylvania, Warrington – Solana Doylestown, The
South Carolina, Greenville – Rolling Green Village
South Carolina, Hilton Head Island – Bayshore on Hilton Head Island
South Carolina, Hilton Head Island – Cypress of Hilton Head, The
Tennessee, Brentwood – Heritage at Brentwood, The
Tennessee, Hendersonville – Clarendale at Indian Lake
Tennessee, Memphis – Heritage at Irene Woods
Tennessee, Nashville – Clarendale at Bellevue Place
Texas, Austin – Westminster
Texas, Bedford – Parkwood Healthcare
Texas, Bedford – Parkwood Retirement
Texas, Dallas – Autumn Leaves
Texas, Dallas – Monticello West
Texas, Dallas – Signature Pointe
Texas, Dallas – Walnut Place
Texas, Georgetown – Delaney at Georgetown Village, The
Texas, League City – Delaney at South Shore, The
Texas, Lubbock – Carillon
Texas, Richmond – Delaney at Parkway Lakes, The
Texas, Spring – Village at Gleannloch Farms, The
Texas, The Woodlands – Village at the Woodlands Waterway, The
Texas, Waco – Delaney at Lake Waco, The
Vermont, White River – Village at White River Junction, The
Virginia, Fairfax – Virginian, The
Virginia, Gainesville – Heritage Village Assisted Living and Memory Care
Washington, Issaquah – Timber Ridge at Talus
Wisconsin, Greendale – Harbour Village
Wisconsin, Milwaukee – Eastcastle Place

EXHIBIT 4

RESIDENCES AT VANTAGE POINT

Virginia M. Thomas
President of the Corporate Board
Residence at Vantage Point
5400 Vantage Point Rd.
Columbia, MD 21244
410-992-7984

June 3, 2025

To Whom It May Concern,

I am writing on behalf of the Board of Directors of Residences at Vantage Point to formally designate Pierce Carey, Executive Director, as an authorized signer on behalf of the organization.

As Executive Director, Mr. Carey is entrusted with the authority to execute documents, enter into agreements, and approve transactions as necessary to carry out the operational and administrative functions of Vantage Point. This designation includes completion of the CON application.

If you have any questions or require further confirmation, please feel free to contact me directly at Ginny Thomas ginny.thomas65@gmail.com.

Sincerely,
Virginia M. Thomas

Virginia M. Thomas
President of the Corporate Board
Residences at Vantage Point

EXHIBIT 5

Special Documents

MARYLAND HEALTH CARE COMMISSION

GROSS, NET, AND EFFECTIVE BED NEED PROJECTIONS FOR COMPREHENSIVE CARE FACILITY OR NURSING HOME BEDS, TARGET YEAR 2022

In accordance with COMAR 10.24.20.06, the Maryland Health Care Commission (MHCC) publishes the following notice of jurisdictional gross, net, and effective bed need. These projections update and supersede the projections published in the Maryland Register on April 29, 2016. The effective bed need projection will apply in the review of Certificate of Need applications acted on by MHCC after the date of their publication. Published projections of gross bed need remain in effect until MHCC publishes updated bed need projections. Projections of net bed need and effective bed need can change during the interim period between publication of bed need projections as a result of changes in the bed inventory, changes in average bed occupancy, or changes needed to correct errors in the data or computation of the bed need projections.

	Bed Inventory as of September 1, 2019					2022 Projected Bed Need			
Jurisdiction/ REGION	Licensed Beds	CON-Approved Beds	"Waiver" Beds [1]	Temporarily Delicensed Beds	Total Bed Inventory	Gross Bed Need	Net Bed Need	Average Bed Occupancy 2016-17	Effective Bed Need [2]
WESTERN MARYLAND	**4,235**	**0**	**0**	**131**	**4,366**				
Allegany	908	0	0	0	908	761	-147	85.9%	0
Carroll	921	0	0	0	921	888	-33	88.3%	0
Frederick	1,082	0	0	0	1,082	1,052	-30	88.0%	0
Garrett	317	0	0	0	317	286	-31	88.1%	0
Washington	1,007	0	0	131	1,138	1,005	-133	88.0%	0
MONTGOMERY COUNTY	**4,562**	**0**	**5**	**0**	**4,567**				
Montgomery	4,562	0	5	0	4,567	4,035	-532	86.9%	0
SOUTHERN MARYLAND	**4,303**	**0**	**62**	**8**	**4,373**				
Calvert	292	0	0	0	292	311	19	80.2%	0
Charles	495	0	12	0	507	516	9	91.4%	9
Prince George's	2,953	0	10	0	2,963	2,995	32	92.0%	32
St. Mary's	563	0	40	8	611	581	-30	93.1%	0
CENTRAL MARYLAND	**12114**	**96**	**0**	**130**	**12,340**				
Anne Arundel	1,764	20	0	0	1,784	1,692	-92	89.0%	0
Baltimore City	3,717	0	0	110	3,827	3,379	-448	90.8%	0
Baltimore County	5,288	0	0	20	5,308	4,781	-527	88.2%	0
Harford	769	48	0	0	817	777	-40	90.8%	0
Howard	576	28	0	0	604	617	13	90.2%	13
EASTERN SHORE	**2,599**	**0**	**6**	**48**	**2,653**				
Caroline	187	0	6	0	193	153	-40	83.4%	0
Cecil	431	0	0	23	454	432	-22	85.3%	0
Dorchester	233	0	0	25	258	213	-45	84.4%	0
Kent	228	0	0	0	228	202	-26	81.1%	0
Queen Anne's	120	0	0	0	120	115	-5	81.0%	0
Somerset	211	0	0	0	211	192	-19	89.1%	0
Talbot	269	0	0	0	269	228	-41	83.1%	0
Wicomico	613	0	0	0	613	538	-75	80.9%	0
Worcester	307	0	0	0	307	266	-41	81.6%	0

Notes: [1] "Waiver" beds are small increments of beds that nursing homes may add, under specific conditions, without CON approval. These additions must be implemented within one year after authorization.

[2] Bed need is identified as zero if the current bed inventory exceeds gross bed need or if the two-year average bed occupancy rate is below 90%.

[19-20-18]

EXHIBIT 6

RESIDENCES AT VANTAGE POINT

Virginia M. Thomas
President of the Corporate Board
Residences at Vantage Point
5400 Vantage Point Rd.
Columbia, MD 21044
ginny.thomas65@gmail.com
410-992-7984

June 3, 2025

Wynee Hawk
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Hawk,

On behalf of Residences at Vantage Point (RVP), I am writing to formally express our intent to participate in the Maryland Medicaid program. As Columbia's only Continuing Care Retirement Community (CCRC), RVP has a proud history of delivering exceptional care and services to a diverse population of seniors in Howard County and beyond.

With the anticipated award of 13 public beds, RVP is prepared to extend its award-winning services to Medicaid-eligible residents for the first time in our history. Our CMS 5-Star rated facility is committed to providing high-quality, culturally competent care, ensuring that all residents—regardless of their financial circumstances—have access to a safe, supportive, and enriching environment.

We look forward to collaborating with the Maryland Department of Health to advance health equity and broaden access to high-quality care for Maryland's aging population. Please let us know if additional documentation or information is required to facilitate this process.
Thank you for your attention to this matter. We are eager to begin this important partnership.

Sincerely,

Virginia M. Thomas

Virginia M. Thomas
President of the Corporate Board

EXHIBIT 7

CON TABLE PACKAGE FOR NURSING HOME (CCFs) APPLICATIONS

Name of Applicant: Columbia Vantage House Corp., dba Residences at Vantage Point

Date of Submission:

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

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

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

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

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

TABLE B. PROPOSED NEW CONSTRUCTION AND RENOVATION SQUARE FOOTAGE

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

Gross Square Footage by Floor/Nursing Unit/Wing	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	0	0	0	0	0

TABLE C. PROJECT BUDGET

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

		CCF Nursing Home	Other Service Areas	Total
A.	**USE OF FUNDS**			
1.	**CAPITAL COSTS**			
a.	**New Construction**			
(1)	Building			$0
(2)	Fixed Equipment			$0
(3)	Site and Infrastructure			$0
(4)	Architect/Engineering Fees			$0
(5)	Permits (Building, Utilities, Etc.)			$0
	SUBTOTAL New Construction	**$0**	**$0**	**$0**
b.	**Renovations**			
(1)	Building			$0
(2)	Fixed Equipment (not included in construction)			$0
(3)	Architect/Engineering Fees			$0
(4)	Permits (Building, Utilities, Etc.)			$0
	SUBTOTAL Renovations	**$0**	**$0**	**$0**
c.	**Other Capital Costs**			
(1)	Movable Equipment			$0
(2)	Contingency Allowance			$0
(3)	Gross interest during construction period			$0
(4)	Other *(Specify/add rows if needed)*			$0
	SUBTOTAL Other Capital Costs	***$0***	***$0***	**$0**
	TOTAL CURRENT CAPITAL COSTS	**$0**	**$0**	**$0**
d.	Land Purchased/Donated			
e.	Inflation Allowance			
	TOTAL CAPITAL COSTS	**$0**	**$0**	**$0**
2.	**Financing Cost and Other Cash Requirements**			
a.	Loan Placement Fees			$0
b.	Bond Discount			$0
c	CON Application Assistance			
	c1. Legal Fees			$85,000
	c2. Other -CON Draft Consultant			$20,000
d.	Non-CON Consulting Fees			$0
	d1. Legal Fees			
	d2. Other (Specify/add rows if needed)			$0
e.	Debt Service Reserve Fund			$0
f.	Other *(Specify/add rows if needed)*			$0
	SUBTOTAL	***$0***	***$0***	**$105,000**
3.	**Working Capital Startup Costs**			$0
	TOTAL USES OF FUNDS	***$0***	***$0***	***$105,000***
B.	**Sources of Funds**			
1.	**Cash**			**$105,000**
2.	**Philanthropy (to date and expected)**			$0
3.	**Authorized Bonds**			$0
4.	**Interest Income from bond proceeds listed in #3**			$0
5.	**Mortgage**			$0
6.	**Working Capital Loans**			$0
7.	**Grants or Appropriations**			
a.	**Federal**			$0
b.	**State**			$0
c.	**Local**			$0
8.	**Other *(Specify/add rows if needed)***			$0
	TOTAL SOURCES OF FUNDS			**$105,000**

Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**	**FY 2031**	**FY 2032**
1. ADMISSIONS										
a. Comprehensive Care (public)	n/a	n/a	n/a	45	65	65	65	65	65	65
b. Comprehensive Care (CCRC Restricted)	65	64	65	65	65	65	65	65	65	65
Total Comprehensive Care	**65**	**64**	**65**	**110**	**130**	**130**	**130**	**130**	**130**	**130**
c. Assisted Living	26	21	12	20	20	20	20	20	20	20
d. Other (Independent Living)	18	31	26	24	24	24	24	24	24	24
TOTAL ADMISSIONS	***109***	***116***	***103***	***154***	***174***	***174***	***174***	***174***	***174***	***174***
2. PATIENT DAYS										
a. Comprehensive Care (public)	n/a	n/a	n/a	2,738	3,650	3,650	3,650	3,650	3,650	3,650
b. Comprehensive Care (CCRC Restricted)	6,570	7,574	7,300	6,570	6,570	6,570	6,570	6,570	6,570	6,570
Total Comprehensive Care	**6,570**	**7,574**	**7,300**	**9,308**	**10,220**	**10,220**	**10,220**	**10,220**	**10,220**	**10,220**
c. Assisted Living	12,684	14,326	14,509	14,600	14,600	14,600	14,600	14,600	14,600	14,600
d. Other (Independent Living)	65,791	66,613	67,069	66,795	66,795	66,978	66,795	66,795	66,795	66,978
TOTAL PATIENT DAYS	***85,045***	***88,513***	***88,878***	***90,703***	***91,615***	***91,798***	***91,615***	***91,615***	***91,615***	***91,798***
3. NUMBER OF BEDS										
a. Comprehensive Care (public)	0	0	0	13	13	13	13	13	13	13
b. Comprehensive Care (CCRC Restricted)	44	44	44	31	31	31	31	31	31	31
Total Comprehensive Care Beds	**44**	**44**	**44**	**44**	**44**	**44**	**44**	**44**	**44**	**44**
c. Assisted Living	50	50	50	50	50	50	50	50	50	50
d. Other (Independent Living)	200	200	200	200	200	200	200	200	200	200
TOTAL BEDS	***294***	***294***	***294***	***294***	***294***	***294***	***294***	***294***	***294***	***294***

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**	**FY 2031**	**FY 2032**
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	N/A	N/A	N/A	57.7%	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%
b. Comprehensive Care (CCRC Restricted)	40.9%	47.2%	45.5%	58.1%	58.1%	58.1%	58.1%	58.1%	58.1%	58.1%
Total Comprehensive Care Beds	**40.9%**	**47.2%**	**45.5%**	**58.0%**	**63.6%**	**63.6%**	**63.6%**	**63.6%**	**63.6%**	**63.6%**
c. Assisted Living	69.5%	78.5%	79.5%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
d. Other (Independent Living)	90.1%	91.3%	91.9%	91.5%	91.5%	91.8%	91.5%	91.5%	91.5%	91.8%
TOTAL OCCUPANCY %	**79.3%**	**82.3%**	**82.8%**	**84.5%**	**85.4%**	**85.3%**	**85.4%**	**85.4%**	**85.4%**	**85.3%**
5. OUTPATIENT (specify units used for charging and recording revenues)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
a. Adult Day Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. UTILIZATION PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**	**FY 2031**	**FY 2032**
1. ADMISSIONS							
a. Comprehensive Care (public)	45	65	65	65	65	65	65
b. Comprehensive Care (CCRC Restricted)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Comprehensive Care	**45**	**65**	**65**	**65**	**65**	**65**	**65**
c. Assisted Living	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL ADMISSIONS	***45***	***65***	***65***	***65***	***65***	***65***	***65***
2. PATIENT DAYS							
a. Comprehensive Care (public)	2,738	3,650	3,660	3,650	3,650	3,650	3,660
b. Comprehensive Care (CCRC Restricted)	0	0	0	0	0	0	0
Total Comprehensive Care	**2,738**	**3,650**	**3,660**	**3,650**	**3,650**	**3,650**	**3,660**
c. Assisted Living	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL PATIENT DAYS	***2,738***	***3,650***	***3,660***	***3,650***	***3,650***	***3,650***	***3,660***
3. NUMBER OF BEDS	13	13	13	13	13	13	13
a. Comprehensive Care (public)	13	13	13	13	13	13	13
b. Comprehensive Care (CCRC Restricted)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Comprehensive Care Beds	**13**	**13**	**13**	**13**	**13**	**13**	**13**
c. Assisted Living	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL BEDS	***13***	***13***	***13***	***13***	***13***	***13***	***13***
4. OCCUPANCY PERCENTAGE *IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. Comprehensive Care (public)	57.7%	76.9%	77.1%	76.9%	76.9%	76.9%	77.1%
b. Comprehensive Care (CCRC Restricted)	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Total Comprehensive Care Beds	**57.7%**	**76.9%**	**77.1%**	**76.9%**	**76.9%**	**76.9%**	**77.1%**
c. Assisted Living	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
d. Other (Specify/add rows of needed)	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
TOTAL OCCUPANCY %	**57.7%**	**76.9%**	**76.9%**	**76.9%**	**76.9%**	**76.9%**	**76.9%**
5. OUTPATIENT (specify units used for charging and recording revenues)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
a. Adult Day Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b. Other (Specify/add rows of needed)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**	**FY 2031**	**FY 2032**
1. REVENUE										
a. Inpatient Services	$ 16,521,109	$ 18,968,459	$ 19,724,252	$ 20,872,698	$ 21,273,531	$ 21,277,776	$ 21,273,531	$ 21,273,531	$ 21,273,531	$ 21,277,776
b. Outpatient Services	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gross Patient Service Revenues	***$ 16,521,109***	***$ 18,968,459***	***$ 19,724,252***	***$ 20,872,698***	***$ 21,273,531***	***$ 21,277,776***	***$ 21,273,531***	***$ 21,273,531***	***$ 21,273,531***	***$ 21,277,776***
c. Allowance For Bad Debt	$ -	$ 102,302	$ 65,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
d. Contractual Allowance	$ 537,536	$ 616,302	$ 643,679	$ 835,304	$ 935,679	$ 936,479	$ 935,679	$ 935,679	$ 936,479	$ 936,479
e. Charity Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Net Patient Services Revenue	***$ 15,983,573***	***$ 18,249,855***	***$ 19,015,573***	***$ 19,987,394***	***$ 20,287,852***	***$ 20,291,297***	***$ 20,287,852***	***$ 20,287,852***	***$ 20,287,052***	***$ 20,291,297***
f. Other Operating Revenues (Interest Income)	$ 209,479	$ 318,044	$ 72,000	$ 72,000	$ 72,000	$ 72,000	$ 72,000	$ 72,000	$ 72,000	$ 72,000
f. Other Operating Revenues (Space Rentals)	$ 57,342	$ 58,522	$ 62,000	$ 62,000	$ 62,000	$ 62,000	$ 62,000	$ 62,000	$ 62,000	$ 62,000
NET OPERATING REVENUE	***$ 16,193,052***	***$ 18,567,899***	***$ 19,087,573***	***$ 20,059,394***	***$ 20,359,852***	***$ 20,363,297***	***$ 20,359,852***	***$ 20,359,852***	***$ 20,359,052***	***$ 20,363,297***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 8,767,900	$ 8,660,650	$ 9,267,709	$ 9,872,804	$ 10,036,009	$ 10,038,114	$ 10,036,009	$ 10,036,009	$ 10,036,009	$ 10,038,114
b. Contractual Services	$ 451,983	$ 571,769	$ 614,649	$ 806,274	$ 906,649	$ 907,449	$ 906,649	$ 906,649	$ 907,449	$ 907,449
c. Interest on Current Debt	**$ 2,242,600**	**$ 2,168,054**	**$ 2,114,552**	**$ 2,080,250**	**$ 2,038,645**	**$ 1,997,872**	**$ 1,957,915**	**$ 1,918,756**	**$ 1,880,381**	**$ 1,842,774**
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Current Depreciation	$ 3,331,402	$ 3,514,261	$ 3,486,780	$ 3,547,862	$ 3,547,862	$ 3,547,862	$ 3,547,862	$ 3,547,862	$ 3,547,862	$ 3,547,862
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
g. Current Amortization	***$ 10,602***	***$ 10,497***	***$ 12,089***	***$ 13,500***	***$ 13,500***	***$ 13,500***	***$ 13,500***	***$ 13,500***	***$ 13,500***	***$ 13,500***
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
i. Supplies	$ 943,212	$ 848,183	$ 745,361	$ 759,051	$ 767,261	$ 767,261	$ 767,261	$ 767,261	$ 767,261	$ 767,261
j. Other Expenses (Utilities)	$ 574,746	$ 613,046	$ 802,330	$ 802,330	$ 802,330	$ 802,330	$ 802,330	$ 802,330	$ 802,330	$ 802,330
j. Other Expenses (Food)	$ 963,991	$ 1,029,358	$ 1,108,850	$ 1,138,641	$ 1,149,000	$ 1,149,000	$ 1,149,000	$ 1,149,000	$ 1,149,000	$ 1,149,000
j. Other Expenses (Marketing)	$ 430,698	$ 461,051	$ 409,947	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000	$ 475,000
j. Other Expenses (Administrative)	$ 2,674,998	$ 3,190,796	$ 3,098,323	$ 3,148,045	$ 3,138,100	$ 3,138,100	$ 3,138,100	$ 3,138,100	$ 3,138,100	$ 3,138,100
TOTAL OPERATING EXPENSES	**$ 20,392,132**	**$ 21,067,665**	**$ 21,660,590**	**$ 22,643,757**	**$ 22,874,356**	**$ 22,836,488**	**$ 22,793,625**	**$ 22,754,467**	**$ 22,716,892**	**$ 22,681,389**

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**	**FY 2031**	**FY 2032**
3. INCOME										
a. Income From Operation	**$ (4,199,080)**	**$ (2,499,766)**	**$ (2,573,017)**	**$ (2,584,363)**	**$ (2,514,504)**	**$ (2,473,191)**	**$ (2,433,773)**	**$ (2,394,615)**	**$ (2,357,840)**	**$ (2,318,092)**
b. Non-Operating Income	$ 1,824,117	$ 2,219,634	$ 2,892,292	$ 2,650,000	$ 2,650,000	$ 2,650,000	$ 2,650,000	$ 2,650,000	$ 2,650,000	$ 2,650,000
SUBTOTAL	***$ (2,374,963)***	***$ (280,132)***	***$ 319,275***	***$ 65,637***	***$ 135,496***	***$ 176,809***	***$ 216,227***	***$ 255,385***	***$ 292,160***	***$ 331,908***
c. Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NET INCOME (LOSS)	***$ (2,374,963)***	***$ (280,132)***	***$ 319,275***	***$ 65,637***	***$ 135,496***	***$ 176,809***	***$ 216,227***	***$ 255,385***	***$ 292,160***	***$ 331,908***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	3.5%	3.5%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
2) Medicaid	0.0%	0.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
3) Blue Cross										
4) Commercial Insurance	0.3%	0.7%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
5) Self-pay										
6) CCRC Residents	96.2%	95.8%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days										
1) Medicare	1.2%	1.5%	1.6%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%
2) Medicaid	N/A	N/A	N/A	1.51%	1.99%	1.99%	1.99%	1.99%	1.99%	1.99%
3) Blue Cross										
4) Commercial Insurance	0.1%	0.2%	0.4%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
5) Self-pay										
6) CCRC Residents	98.7%	98.3%	98.0%	95.3%	94.8%	94.8%	94.8%	94.8%	94.8%	94.8%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE I. Scheduled Staff for Typical Work Week

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

	Weekday Hours Per Day					Weekend Hours Per Day				Pierce
Staff Category	**Day**	**Evening**	**Night**	**Total**		**Day**	**Evening**	**Night**	**Total**	
Registered Nurses	8	8	8	24		8	8	8	24	
L. P. N. s	8	8	0	16		8	8		16	
Aides				0					0	
C. N. A.s	22.5	15	15	52.5		22.5	15	15	52.5	
Medicine Aides				0						
Total	38.5	31	23	92.5		38.5	31	23	92.5	
Licensed Beds at Project Completion						**Licensed Beds at Project Completion**				
Hours of Bedside Care per Licensed Bed per Day						**Hours of Bedside Care per Licensed Bed Per Day**				

	Weekday Hours Per Day					Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**		**Day**	**Evening**	**Night**	**Total**
Ward Clerks (bedside care time calculated at 50%									
Total Including 50% of Ward Clerks Time									
Total Hours of Bedside Care per Licensed Bed Per Day						**Total Hours of Bedside Care per Licensed Bed Per Day**			

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

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

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

TABLE H. WORKFORCE INFORMATION

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

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

TABLE H. WORKFORCE INFORMATION

2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**											
TOTAL COST	***153.6***		***$8,043,260***	***12.0***		***$591,000***	***0.0***		***$0***		***$8,634,260***

TABLE J. CONSTRUCTION CHARACTERISTICS

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

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

*As defined by Marshall Valuation Service

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

N/A

.

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation		
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs		
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$0**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$0**	**$0**

N/A

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

EXHIBIT 8

Admission Criteria

Policy Statement

Our facility admits only residents whose medical and nursing care needs can be met.

Policy Interpretation and Implementation

1. The objectives of our admission criteria policy are to:
   a. provide uniform criteria for admitting residents to the facility;
   b. admit residents who can be cared for adequately by the facility;
   c. address concerns of residents and families during the admission process;
   d. review with the resident, and/or his/her representative, the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.; and
   e. assure that the facility receives appropriate medical and financial records prior to or upon the resident's admission.

2. Residents (and potential residents) are not asked or required to:
   a. waive their rights to Medicare or Medicaid benefits;
   b. submit written assurance that they are not eligible for or will not apply for Medicare or Medicaid benefits;
   c. waive facility liability for losses of personal property; or
   d. provide a third party guarantee of payment as a condition of admission, expected admission or continued stay.

3. Resident representatives may be requested to or required to sign a contract or agreement that he or she will provide facility payment from the resident's income or resources as long as the representative:
   a. has legal access to the resident's income or resources; and
   b. is not incurring personal financial liability to the facility.

4. Prior to admission, the resident or representative is informed of any service limitations or special characteristics of the facility.

5. Prior to or at the time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident, including orders covering at least:
   a. type of diet (e.g., regular, mechanical, etc.);
   b. medication orders, including (as necessary) a medical condition or problem associated with each medication; and
   c. routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed interdisciplinary care plan.

6. Residents are admitted to this facility as long as their needs can be met adequately by the facility. Examples of conditions that can be treated adequately in this facility include:
   a. diabetes;
   b. COPD;
   c. neuromuscular disorders;
   d. dementia;

continues on next page

e. _____;
f. _____; and
g. _____.

7. Examples of nursing/medical needs that can be met adequately include:
   a. medication management;
   b. limited mobility;
   c. post-operative care needs;
   d. incontinence;
   e. catheterization (urinary or intravenous);
   f. enteral nutrition;
   g. _____;
   h. _____; and
   i. _____.

8. The acceptance of residents with certain conditions or needs may require authorization or approval by the medical director, director of nursing services, and/or the administrator.

9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process.
   a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.
   b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.
      (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD.
      (2) The social worker is responsible for making referrals to the appropriate state-designated authority.
   c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.
   d. The state PASARR representative provides a copy of the report to the facility.
   e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation.
   f. Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified.

10. The preadmission screening program requirements do not apply to residents who, after being admitted to the facility, were transferred to a hospital.

11. The state may choose not to apply the preadmission screening requirement if:
   a. the individual is admitted directly to the facility from a hospital where he or she received acute inpatient care;
   b. the individual requires facility services for the condition for which he or she received care in the hospital; and
   c. the attending physician has certified (prior to admission) that the individual will likely need less than 30 days of care at the facility.

continues on next page

12. Our admission policies apply to all residents admitted to the facility regardless of race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital or veteran status, and/or payment source.

13. The administrator, through the admissions department, ensures that the resident and the facility follow applicable admission policies.

References	
OBRA Regulatory Reference Numbers	§483.15(a) Admissions policy; §483.20(e) Coordination; §483.20(k)
Survey Tag Numbers	F620; F644; F645
Other References	http://www.pasrrassist.org/resources/personnel/pasrr-state-lead-contactinformation SOM – Appendix PP Definition "Mental disorder"
Related Documents	Acute Condition Change – Clinical Protocol Care Plans, Comprehensive Person-Centered
Version	2.1 (H5MAPL0047)

EXHIBIT 9

Gilchrist is a proud partner of Residences at Vantage Point. Our partnership includes supporting residents with end-of-life care, counseling and support, and education on various healthcare topics.

We work in tandem with the team at Residences at Vantage Point to provide extra care and guidance to your residents and their families. Decision making is a joint process that involves the input of the patient, family, and medical personnel from both Residences at Vantage Point and Gilchrist.

Our team will:

- Provide additional hands-on care through weekly nursing visits and personal care from hospice aides.
- Manage medications, pain and other symptoms.
- Assess the patient's physical condition.
- Educate family about what to expect.
- Assist families through the intense emotions and spiritual questions that often accompany the dying process.
- Provide volunteer companionship, as needed.
- Offer companions at the bedside (end-of-life doulas) as death nears to ensure that no one dies alone and that the family has the support they need during this difficult time.

At Gilchrist, we are honored to help patients and their loved ones navigate the complexities of advancing age, serious illness, and end-of-life care with a comprehensive array of services that meet life's ever-changing physical, psychological, spiritual, and emotional needs. Because no two journeys are the same, our integrated care model extends the highest quality clinical and compassionate care wherever it is needed most—across care settings, private residences, and senior living communities.

Families navigating their loved one's healthcare may have many questions, and need someone to walk them through our service offerings. We have a dedicated phone line staffed by highly trained, knowledgeable care navigators to listen to the caller's needs and discuss options for care. The team is available 24/7 to answer questions and guide patients to the right services and. resources within Gilchrist and in the community-- so they get the answers they need quickly and efficiently.

Care Navigators will:

- Listen to concerns
- Ask questions about the patient's current care and help determine their needs
- Discuss care options and assist in deciding on the right services for them
- Immediately schedule an appointment with the appropriate Gilchrist services, if needed
- Link them to resources both within Gilchrist and in the community

Many families wish to take their loved ones home as they near the end of life and we often receive referrals for hospice upon a resident's discharge from a senior living community such as Vantage Point. Our Access team will ensure patients will have any needed medications, durable medical equipment and supplies in the home prior to discharge and will work with your team to ensure a warm transition to our interdisciplinary team. Tuck-in calls the evening of home hospice admission ensure patients and are comfortable while answering any questions the caregivers may have.

Our newly admitted patients and caregivers have access to Gilchrist's Nurse Helpline, staffed by triage nurses 24 hours a day, seven days a week. Ideally, the triage nurse resolves issues and concerns immediately; if not, the triage nurse will coordinate for call-backs or visits from the interdisciplinary team (IDT) members. The triage nurse documents all phone contacts in the electronic medical record and, when needed, alerts IDT members of patient and family issues, needs and concerns. Gilchrist's efforts to increase communication regarding death and dying are reflected in an increase in the length of stay for our current customers.

Gilchrist also works with CRISP (a regional health information exchange) to maintain a panel of all Gilchrist patients so that our Nurse Helpline can receive timely email notification from CRISP of any current Gilchrist patient admission to an emergency department. This is very helpful in those cases a patient or family member doesn't contact Gilchrist prior to calling 911. We will dispatch a nurse to the ED or provide telephonic support to ensure patients have the information they need to make informed choices. In many cases, we can help avoid acute admissions and facilitate a quick return to the patient's home.

MORNINGSIDE HOUSE
ELLICOTT CITY

To Whom It May Concern:

On behalf of Morningside House Senior Living, I am writing to express our full support for the Residences at Vantage Point (RVP) in their application to reopen their Certificate of Need (CON) Skilled Nursing beds.

As senior living communities serving older adults in Howard County, Morningside House and RVP share a mutual commitment to delivering high-quality, person-centered care. We have long respected RVP as a trusted partner in supporting older adults through key life transitions, including the move into senior living. Our teams have worked collaboratively over the years, and we have confidently referred residents to RVP, knowing they prioritize clinical excellence, resident dignity, and a seamless continuum of care.

The reopening of RVP's skilled nursing beds is a vital step in meeting the increasing demand for comprehensive senior care in our region. These additional beds will expand local capacity, ensuring that older adults—particularly those moving from hospital care or managing chronic conditions—have access to skilled services as part of a supportive pathway into long-term senior living.

Morningside House is pleased to support this initiative and looks forward to strengthening our collaboration with RVP by:

- Coordinating referrals when appropriate to ensure older adults experience smooth, supportive transitions into the level of care best suited to their needs;
- Partnering with RVP's leadership on integrated care planning that aligns with our shared mission to enhance the quality of life for seniors;
- Supporting families in identifying trusted care options through our continued mutual cooperation.

We respectfully encourage the appropriate regulatory authorities to approve RVP's CON application. Doing so will enhance the resources available to our shared community and support older adults as they navigate important transitions in their care journey.

Should additional information be needed, please feel free to contact me directly at **jghartey@mhseniorliving.com**.

EXHIBIT 10

Community-Based Services Guide

Introduction

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

Home Health Care

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

Services Provided:

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

Home Care

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

Services Provided:

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

Hospice Care

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

Services Provided:

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

Conclusion

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

EXHIBIT 11

MDS Assessment Coordinator

Policy Statement

A registered nurse (RN) shall be responsible for conducting and coordinating the development and completion of the resident assessment (MDS).

Policy Interpretation and Implementation

1. A registered nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (MDS).
2. The resident assessment coordinator must date and sign each assessment (MDS) to certify that the assessment has been completed.
3. Each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by:
   a. dating and signing the assessment (MDS); and
   b. identifying each section completed.
4. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action and such incident must be promptly reported to the administrator.

References	
OBRA Regulatory Reference Number	§483.20(g) Accuracy of Assessments.; §483.20(h) Coordination.; §483.20(i) Certification. §483.20(j) Penalty for Falsification.
Survey Tag Number	F641; F642
Other References	
Related Documents	
Version	1.2 (H5MAPL0487)
Revision Date	November 2019

MDS Error Correction

Policy Statement

The assessment coordinator and/or the interdisciplinary assessment team will follow the established processes for making corrections to the MDS.

Policy Interpretation and Implementation

5. Once completed, edited and accepted into the QIES ASAP system, MDS data may not be changed just because the resident's status has changed during the course of his or her stay at the facility.
   c. Minor changes in condition or status are documented in the resident's medical record and adjustments in care or services are made in accordance with standards of clinical practice.
   d. Major changes in the resident's status may prompt a significant change in status assessment, as described below.
6. Note that the QIES ASAP system has defined record rejection standards and data that is outside the reference range will not be accepted by the system (e.g., a 4 is entered when only 0-3 are allowable responses).
7. If an error in data is discovered within 7 days of the completion of the MDS and before submission to the QIES ASAP system (the "encoding and editing period"):
   a. The correction is made to the hard copy of the form using standard editing procedures (cross out, enter correct response, initial and date);
   b. Corresponding corrections are made to the facility's MDS database. (Note: Software used to encode the MDS runs all standard edits as defined in the CMS data specifications); and
   c. The resident's care plan is reviewed and modified as necessary.
8. If an error is discovered after the encoding and editing period and the record in error is an entry, discharge or PPS assessment, then correct the record and submit to the QIES ASAP system.
9. If an error is discovered after the encoding period and the record in error is an OBRA assessment, determine if the error is major or minor.
   a. A minor error is one related to the coding of the MDS. For minor errors, correct the record and submit to the QIES ASAP system.
   b. A major error is one that inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. For major errors:
      1. correct the original assessment to reflect the resident's status as of the original assessment reference date and submit the record; AND
      2. perform a new significant change in status (if this has occurred) OR a new significant correction to a prior assessment with a new observation period and assessment reference date.
10. If an error is discovered in a record that has already been accepted by the QIES ASAP system, implement procedures for either modification or inactivation of the information in the system within 14 days of the discovery of the error.
11. Modification requests are used when information in the record contains clinical or demographic errors. [Note: The only MDS items that cannot be altered with a modification request are: Type

of Provider (A0200), Submission Requirement A0410); and the state-assigned facility submission ID (FAC_ID). These items require a special manual record correction request.]

12. To modify errors in entry, PPS, or discharge records that are not OBRA:
    a. create a corrected record with all items included, not just the items in error;
    b. complete the correction request section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a modification request.); and
    c. submit the modification request record.
13. To modify errors in an OBRA assessment when the errors are minor:
    a. create a corrected record with all items included, not just the items in error;
    b. complete the correction request section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a modification request.); and
    c. submit the modification request record.
14. To modify errors in an OBRA assessment when the errors are major:
    a. create a corrected record with all items included, not just the items in error;
    b. complete the correction request section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a modification request.);
    c. submit the modification request record; and
    d. perform a new significant change in status assessment (if this has occurred) OR a new significant correction of a prior assessment.
15. Inactivation requests are used when a record has been accepted to the QIES ASAP system but the corresponding event did not occur (e.g., a discharge record was submitted for a resident but there was no discharge).
16. To submit an inactivation request, complete and submit an MDS record with only section X items completed.
17. For manual record correction request instructions, refer to the RAI User's Manual.

References	
OBRA Regulatory Reference Number	§483.20(f) Automated data processing requirement-
Survey Tag Number	F640
Other References	Long-Term Care Facility RAI User's Manual Version 3.0, Chapter 5
Related Documents	
Version	1.1 (H5MAPL0488)
Revision Date	September 2010

MDS Completion and Submission Timeframes

Policy Statement

Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.

Policy Interpretation and Implementation

1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines.
2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.
3. Submission of MDS records to the QIES ASAP is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of fifteen (15) months from the date submitted.

References	
OBRA Regulatory Reference Number	§483.20(d) Use
Survey Tag Number	F639
Other References	
Related Documents	RAI OBRA-required Assessment Summary
Version	1.2 (H5MAPL0489)
Revision Date	July 2017

EXHIBIT 12

PointClickCare

Residences at Vantage Point SNF

Pierce Carey

Home Admin Clinical QIA Insights Document Manager Reports

Search resident, room #, ID #... Search

Functional Abilities and Goals - Discharge - V 2

Resident: [redacted]
Description: Discharge
Date: 5/8/2025 11:56
Section Status: Signed
Lock Date: 5/9/2025 12:04

Cancel

SECTION Cust. Functional Abilities and Goals - Discharge - V 2

.		**1.** MDS Reason for Evaluation H (•) 1. Discharge (stand-alone or combination) ( ) 2. PPS Discharge (stand-alone) **2.** Dates for 3-Day Window: (Information provided should reflect USUAL status during THIS window) H 5/8/25 Usual performance was based on direct observation, the residents self-report, family reports and direct-care staff reports of resident's self-care status **3A.** IDT Collaboration included the Following: H ☐ a. Director of Rehab ☐ b. MDS Nurse ☑ c. Licensed Nurse ☐ d. Therapist ☐ e. Other **3B.** Additional Information H 5/8/25
GG.	Self-Care & Mobility	(Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03 Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason. H Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance Activities may be completed with or without assistive devices. H
Coding.	Instructions	**06.** Independent-Resident completes the activity by themself with no assistance from a helper. H **05.** Setup or clean-up assistance - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity. H **04.** Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. H **03.** Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. H **02.** Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. H If activity was not attempted, code reason: **07.** Resident refused. H **09.** Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. H **10.** Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints). H **88.** Not attempted due to medical condition or safety concerns. H **dash.** Not assessed/no information H

		01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. H
130.	Self-Care	(Assessment period is the last 3 days of the stay) **1.** Complete column 3 when A310F = 10 or 11 or when A310H = 1. H When A0310G is not = 2 AND A0310H = 1 AND A2400C minus A2400B is greater than 2 AND A2105 is not = 04, the stay ends on A2400C. **2.** For all other Discharge assessments, the stay ends on A2000. H **A3.** Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. - Discharge Performance **MDS** H 06. Independent 05. Setup or clean-up assistance 04. Supervision or touching assistance 03. Partial/moderate assistance 02. Substantial/maximal assistance 01. Dependent 07. Resident refused 09. Not applicable 10. Not attempted due to environmental limitations 88. Not attempted due to medical condition or safety concerns -. Not assessed/no information **B3.** Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.- Discharge Performance **MDS** H 06. Independent 05. Setup or clean-up assistance 04. Supervision or touching assistance 03. Partial/moderate assistance 02. Substantial/maximal assistance 01. Dependent 07. Resident refused 09. Not applicable 10. Not attempted due to environmental limitations 88. Not attempted due to medical condition or safety concerns -. Not assessed/no information **C3.** Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. - Discharge Performance **MDS** H 06. Independent 05. Setup or clean-up assistance 04. Supervision or touching assistance 03. Partial/moderate assistance 02. Substantial/maximal assistance 01. Dependent 07. Resident refused 09. Not applicable 10. Not attempted due to environmental limitations 88. Not attempted due to medical condition or safety concerns

-. Not assessed/no information

E3. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. - Discharge Performance **MDS** H

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

F3. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. - Discharge Performance **MDS** H

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

G3. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. - Discharge Performance **MDS** H

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

H3. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. - Discharge Performance **MDS** H

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent

07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

I3. Personal Hygiene (Dschg Perf) **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

170. Mobility

A3. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

B3. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

C3. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance

- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

D3. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. - Discharge Performance **MDS** H

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

E3. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). - Discharge Performance **MDS** H

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

F3. Toilet transfer: The ability to get on and off a toilet or commode. - Discharge Performance **MDS** H

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial/moderate assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. Resident refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- -. Not assessed/no information

FF. Tub/Showr Transfer (Dschg Perf) **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

G3. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

I3. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

J3. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations

88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

K3. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

L3. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

M3. 1 step (curb): The ability to go up and down a curb and/or up and down one step. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

N3. 4 steps: The ability to go up and down four steps with or without a rail. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent

07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

O3. 12 steps: The ability to go up and down 12 steps with or without a rail. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

P3. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

Q3. Does the resident use a wheelchair and/or scooter? - Discharge Performance **MDS** H

0. No
1. Yes
-. Not assessed/no information

R3. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns
-. Not assessed/no information

RR. Indicate the type of wheelchair or scooter used. - Discharge Performance **MDS** H

1. Manual
2. Motorized

-. Not assessed/no information

S3. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. - Discharge Performance **MDS** H

06. Independent
05. Setup or clean-up assistance
04. Supervision or touching assistance
03. Partial/moderate assistance
02. Substantial/maximal assistance
01. Dependent
07. Resident refused
09. Not applicable
10. Not attempted due to environmental limitations
88. Not attempted due to medical condition or safety concerns

-. Not assessed/no information

SS. Indicate the type of wheelchair or scooter used. - Discharge Performance **MDS** H

1. Manual
2. Motorized

-. Not assessed/no information

SECTION Cust. Functional Abilities and Goals - Discharge - V 2

Cancel

Click Here to View Quick Entry - Keyboard Navigation Tips

Residences at Vantage Point SNF
5400 Vantage Point Road
Columbia, MD 21044-2681
Phone: (410) 992-1220 | Fax: (410) 964-2797
PCC Facility ID: 5090

PointClickCare
5570 Explorer Drive
Mississauga, Ontario L4W 0C4

Privacy Policy
Version 4.4.42.2 www30-pcc-web-main-c45b79cff-j975h
Copyright 2000-2025 PointClickCare Technologies Inc. All rights reserved.

EXHIBIT 13

Transfer or Discharge, Facility-Initiated

Policy Statement

Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.

Policy Interpretation and Implementation

1. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless:
   a. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility;
   b. the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by this facility;
   c. the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
   d. the health of individuals in the facility would otherwise be endangered;
   e. the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility.
      (1) Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.
      (2) For a resident who becomes eligible for Medicaid after admission to a facility, the facility will charge a resident only allowable charges under Medicaid; or
   f. the facility ceases to operate.

2. "Transfer and discharge" includes movement of a resident from a certified bed in the facility to a non-certified bed in another part of the facility, or to a non-certified bed outside the facility. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically:
   a. transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility; and
   b. discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

Facility-Initiated Transfer or Discharge

1. "Facility-initiated transfer or discharge" means a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

2. In some cases residents are admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation program, they communicate that they are not ready to

leave the facility. In these situations, if the facility proceeds with discharge, it is considered a facility-initiated discharge.

3. A resident's declination of treatment is not grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others.
   a. The facility will document that the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment and that staff conducted the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others.

Non-Payment as a Basis for Discharge

1. Non-payment for a stay in the facility occurs when the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility and also may apply:
   a. when the resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or
   b. after the third party payer (including Medicare or Medicaid) denied the claim and the resident refused to pay for his/her stay.
2. The facility will notify the resident of their change in payment status, and ensure the resident has the necessary assistance to submit any third party paperwork.
3. In situations where a resident representative has failed to pay, the facility may discharge the resident for nonpayment; however, if there is evidence of exploitation or misappropriation of the resident's funds by the representative, the facility will take steps to notify the appropriate authorities on the resident's behalf, before discharging the resident.
4. In situations where a resident's Medicare coverage may be ending, the facility will comply with the requirements at §483.10(g)(17) and (18), F582.
5. If the resident continues to need long-term care services, the facility, under the requirements above, will offer the resident the ability to remain, which may include:
   a. offering the resident the option to remain in the facility by paying privately for a bed;
   b. providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with §483.10(g)(13), F579, with an explanation that:
      (1) if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and
      (2) if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.
6. If a resident's initial Medicaid application is denied but appealed, this suspends "non-payment" status while the appeal is pending.
7. For a resident who becomes eligible for Medicaid after admission to a facility, the facility will charge a resident only allowable charges under Medicaid. Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

Notice of Transfer or Discharge (Planned)

1. Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility.

2. The resident and representative are notified in writing of the following information:
    a. The specific reason for the transfer or discharge, including the basis under §483.15(c)(1)(i)(A)-(F);
    b. The effective date of the transfer or discharge;
    c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged;
    d. An explanation of the resident's rights to appeal the transfer or discharge to the state, including:
        (1) the name, address, email and telephone number of the entity which receives such appeal hearing requests;
        (2) information about how to obtain an appeal form; and
        (3) how to get assistance in completing and submitting the appeal hearing request;
    e. The Notice of Facility Bed-Hold and policies;
    f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman;
    g. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies);
    h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and
    i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.
3. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.
4. If information in the notice changes, the facility will update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately.
5. For significant changes, such as a change in the transfer or discharge destination, a new notice will be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30-day advance notification and permit adequate time for discharge planning.

Notice of Transfer or Discharge (Emergent or Therapeutic Leave)

1. When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected.
2. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility.
3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge:
    a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;
    b. The resident's health improves sufficiently to allow a more immediate transfer or discharge;
    c. An immediate transfer or discharge is required by the resident's urgent medical needs; or
    d. A resident has not resided in the facility for 30 days.

4. **Notice of Transfer** is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements).
5. **Notice of Facility Bed-Hold and Return** policies are provided to the resident and representative within 24 hours of emergency transfer.
6. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments.
7. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.

Notice of Discharge after Transfer

1. If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care).
2. If the facility does not permit a resident's return to the facility (i.e., initiates a discharge) based on inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights.
3. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman.
4. Notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative.
5. If a resident chooses to appeal a discharge, the facility will not discharge residents while the appeal is pending.
6. If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the facility during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

Appealing Transfer or Discharge

1. Residents have the right to appeal a facility-initiated transfer or discharge through the state agency that handles appeals.
2. Upon notice of transfer or discharge, the resident will be provided with a statement of his or her right to appeal the transfer or discharge, including:
   a. the name, address, email and telephone number of the entity which receives such requests;
   b. information about how to obtain, complete and submit an appeal form;
   c. how to get assistance completing the appeal process; and
   d. the facility bed-hold policy.
3. The facility will assist the resident in filing the appeal, if such assistance is requested.
4. If a resident exercises his or her right to appeal a transfer or discharge notice he or she will not be transferred or discharged while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.

5. If the resident is transferred or discharged despite his or her pending appeal, the danger that failure to transfer or discharge would pose is documented.

Notice of Facility Closure

1. If the facility is closing, the administrator provides written notices to the residents and the residents' representatives of the impending closure at least sixty (60) days prior to the date of closure.
2. If the facility is closing, the administrator provides the following information to the Office of the State Long-Term Care Ombudsman prior to the impending closure:
   a. Notification of the impending facility closure; and
   b. The plan for the transfer and adequate relocation of the residents.
3. Once written notification of impending closure is submitted to residents and representatives, the facility ceases to admit any new residents.
4. At the time of notification of facility closure, the facility provides each resident and representative with the following information:
   a. The plan for the transfer and adequate relocation of the resident;
   b. The date by which the transfer/relocation will be completed; and
   c. Assurances that the resident will be transferred to the most appropriate facility or setting to meet his or her needs in terms of quality, service and location.
5. In determining the transfer location for a resident, the decision to transfer to a particular location is determined by the needs, choices and best interests of the resident.
6. If the facility's Medicare and Medicaid provider agreement is terminated by the state or by CMS, the state determines the appropriate date for notification and arranges for the transfer of Medicare/Medicaid residents.

Orientation for Transfer or Discharge (Planned)

1. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility.
2. A member of the interdisciplinary team will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place.

Orientation for Transfer or Discharge (Emergent or Therapeutic Leave)

1. The resident is oriented and prepared for a facility-initiated transfer (e.g., hospital emergency room or therapeutic leave) when the resident is expected to return and for an emergent or immediate facility-initiated discharge where a complete discharge planning process is not practicable.
2. For an emergency transfer or discharge to a hospital or other acute care institution, implement the following procedures:
   a. Call 911 if the resident meets clinical/behavioral criteria per facility policy, or assist in obtaining transportation;
   b. Notify the resident's attending physician;
   c. Orient/prepare the resident for transfer; and
   d. Prepare for medical record transfer.

3. Sufficient preparation and orientation for the resident prior to an immediate facility-oriented transfer or discharge includes explaining to the resident where he/she is going and why, and taking steps to minimize his/her anxiety or depression (e.g., working with the resident, representative, or family to ensure that the resident's belongings will be taken care of and transferred to the new location as needed/requested, and ensuring that staff recognize characteristic resident reactions identified during assessment and care planning).
4. Orientation and preparation are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments.
5. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.

Information Conveyed to Receiving Provider

1. Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider:
   a. The basis for the transfer or discharge;
      (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include:
         a) the specific resident needs that cannot be met;
         b) this facility's attempt to meet those needs; and
         c) the receiving facility's service(s) that are available to meet those needs;
   b. Contact information of the practitioner responsible for the care of the resident;
   c. Resident representative information including contact information;
   d. Advance directive information;
   e. All special instructions or precautions for ongoing care, as appropriate such as:
      (1) treatments and devices (oxygen, implants, IVs, tubes/catheters);
      (2) transmission-based precautions such as contact, droplet, or airborne;
      (3) special risks such as risk for falls, elopement, bleeding, or pressure injury; and/or
      (4) aspiration precautions;
   f. Comprehensive care plan goals; and
   g. All other information necessary to meet the resident's needs, including but not limited to:
      (1) resident status, including baseline and current mental, behavioral, and functional status;
      (2) recent vital signs;
      (3) diagnoses and allergies;
      (4) medications (including when last received);
      (5) most recent relevant labs, other diagnostic tests, and recent immunizations;
      (6) a copy of the residents discharge summary; and
      (7) any other documentation, as applicable, to ensure a safe and effective transition of care.

Documentation of Facility-Initiated Transfer or Discharge

1. When a resident is transferred or discharged from the facility, the following information is documented in the medical record:
   a. The basis for the transfer or discharge;

(1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include:
    a) the specific resident needs that cannot be met;
    b) this facility's attempt to meet those needs; and
    c) the receiving facility's service(s) that are available to meet those needs;

b. That an appropriate notice was provided to the resident and/or legal representative;
c. The date and time of the transfer or discharge;
d. The new location of the resident;
e. The mode of transportation;
f. A summary of the resident's overall medical, physical, and mental condition;
g. Disposition of personal effects;
h. Disposition of medications;
i. Others as appropriate or as necessary; and
j. The signature of the person recording the data in the medical record.

2. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge is documented in the resident's clinical record by the resident's attending **physician**:
    a. The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility; or
    b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by a physician:
    a. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; or
    b. The health of individuals in the facility would otherwise be endangered.

4. If the facility determines that the resident cannot return to the facility, the medical record will indicate that the facility made efforts to:
    a. determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services;
    b. ascertain an accurate status of the resident's condition, which can be accomplished via communication between hospital and facility staff and/or through visits by facility staff to the hospital;
    c. find out from the hospital the treatments, medications, and services the facility would need to provide to meet the resident's needs upon returning to the facility. If the facility is unable to provide the treatments, medications, and services needed, the facility may not be able to meet the resident's needs; and
    d. work with the hospital to ensure the resident's condition and needs are within the facility's scope of care, based on its facility assessment, prior to hospital discharge.

References	
OBRA Regulatory Reference Number	§483.15(c)(1) Facility requirements-; §483.15(c)(2) Documentation.; §483.15(c)(3) Notice before transfer.; §483.15(c)(4) Timing of the notice.; §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following; §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.; §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).; §483.15(c)(7) Orientation for transfer or discharge.; §483.15(e)(1) Permitting residents to return to facility.; §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.
Survey Tag Number	F622; F623; F624; F626
Other References	
Related Documents	
Version	1.0 (H5MAPL1559)
Revision Date	October 2022

Transfer or Discharge, Resident-Initiated

Policy Statement

Residents may initiate a transfer or discharge from the facility.

Policy Interpretation and Implementation

5. "Transfer" refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.
6. "Discharge" refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.
7. "Resident-initiated transfer or discharge" means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).
    e. Therapeutic leave is a type of resident-initiated transfer. However, if the facility makes a determination to not allow the resident to return, the transfer becomes a facility-initiated discharge.
    f. A resident's lack of objection to a facility-initiated transfer or discharge is not considered "resident-initiated."
    g. A resident's declination of treatment is not considered a resident-initiated discharge.
    h. A resident's verbal or written notice of intent to leave "against medical advice" is considered a resident-initiated discharge.

Documentation

8. For resident-initiated discharges, the medical record contains:
    i. documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility;
    j. a discharge care plan; and
    k. documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care (per F660, Discharge Planning Process, and F661, Discharge Summary).
9. The comprehensive care plan contains the resident's goals for admission and desired outcomes, which will be in alignment with the discharge if it is resident-initiated.

Information Conveyed to Receiving Provider

10. If the resident is being transferred, and return is expected, the following information is conveyed to the receiving provider:
    l. Contact information of the practitioner who was responsible for the care of the resident;
    m. Resident representative information, including contact information;
    n. Advance directive information;
    o. All special instructions and/or precautions for ongoing care, as appropriate such as:

(2) treatments and devices (oxygen, implants, IVs, tubes/catheters);transmission-based precautions such as contact, droplet, or airborne; and
(3) special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;

p. The resident's comprehensive care plan goals;
q. All other information necessary to meet the resident's needs, which includes, but may not be limited to:
(4) resident status, including baseline and current mental, behavioral, and functional status;
(5) reason for transfer, recent vital signs;
(6) diagnoses and allergies;
(7) medications (including when last received); and
(8) most recent relevant labs, other diagnostic tests, and recent immunizations; and
r. additional information, if any, outlined in the transfer agreement with the acute care provider (per §483.70(j)).

11. The above information is conveyed as close as possible to the actual time of transfer.
12. Information may be conveyed using a universal transfer form or an electronic health record summary, as long as the method contains the required elements, the resident's privacy is protected and the receiving facility has the capacity to receive and use the information.
13. For residents being discharged (return not expected), all of the information listed above is conveyed to the receiving provider, along with a copy of the required information found at §483.21(c)(2) Discharge Summary (F661), as applicable.
14. Communication of this required information will occur as close as possible to the time of discharge.

Required Notices

15. For resident-initiated transfers or discharges, sending a copy of the resident's notice of intent to leave the facility to the ombudsman is not required.

References	
OBRA Regulatory Reference Number	§483.15(c)(1) Facility requirements-; §483.15(c)(2) Documentation.; §483.15(c)(3)-(6); §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
Survey Tag Number	F622; F623
Other References	
Related Documents	

References	
Version	1.0 (H5MAPL1560)
Revision Date	October 2022

EXHIBIT 14

THW
DESIGN

April 11, 2025

Wynee Hawk (Director, Center for Health Care Facilities Planning & Development)
Ewurama Shaw-Taylor, PhD (Chief, Certificate of Need)
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Subject: Certification of Compliance with FGI Guidelines

Dear Wynee and Ewurama,

THW Design has been engaged by Residences at Vantage Point to provide consulting services for their Certificate of Need (CON) application and future long-range planning. Our firm has reviewed the facility's drawings and has developed an understanding of the community and its physical environment. I am writing to affirm that it is our professional opinion that the Residences at Vantage Point (RVP) is in alignment with the intent and spirit of the 2022 edition of the Facility Guidelines Institute (FGI) Guidelines for an appropriate living environment for a renovation project. We understand that the RVP project does not actually involve renovation or construction which would be subject to the FGI Guidelines, but also recognize that the Maryland Health Care Commission (the "Commission") requires demonstration of an appropriate living environment using the FGI Guidelines as a point of reference. Except as will be noted below, the project, as outlined and defined in RVP's letter to the Maryland Health Care Commission (the "Commission") responding to the State Health Plan standard COMAR 10.24.20.05A(4) regarding an appropriate living environment (the "Letter"), complies with applicable sections of the FGI Guidelines for a renovation project.

The project deviates from specific FGI requirements in some respects primarily because it was built long before the current FGI Guidelines came into effect. In those instances in which there are deviations from current FGI requirements, the facility has implemented alternative or supplemental measures to uphold the intent of these guidelines. The measures detailed in the Letter outline that the facility meets regulatory expectations. Additionally, we understand that the facility has established policies and procedures to address any areas where physical deviations are found to occur, further supporting compliance with industry best practices and regulatory requirements.

If you need any additional information or clarification, please do not hesitate to contact us.

Sincerely,

Eric Krull, AIA, LEED GA, CASP
Executive Vice President
THW Design
2100 RiverEdge Parkway
Suite 900
Atlanta, GA 30328
(770) 916-2284
erickrull@thw.com

EXHIBIT 15

Monthly Quality Assurance
Agenda

Meeting Date: Tuesday, May 20 2025
Time: 11:30 AM
Location: Residences at Vantage Point Columbia
Zoom link: Please see Calendar Invitation

1. **Approval of Minutes:**
   April 2025

2. **Reporting:**
Monthly Report Period – Apr 2025:
   - Dietician/Dining Services
   - Medical Director
   - Health Services
   - GNA (verbal)
   - Aspen Place / Monterey Place
   - Wellness - RSA
   - Rehab Services
   - Social Work
   - Life Enrichment Services
   - Plant Operations
   - Environmental Services

3. **Quarterly Report Period:**
April – June 2025 (due July 2025 Mtg):
   - Psychologist – PAPPs
   - CounterPoint Health Services
   - Pharmacy – Omni Care
   - X-Ray - TridentCare
   - Human Resources
   - Gilchrist Hospice

4. **Performance Improvement Project (PIP) Updates**
   a. Assisted Living POC
   b. SNF Annual Survey
   c. LSC Survey

5. **Administrator Updates**
   a. Monthly Resident Satisfaction

Upcoming Meetings:

Monthly:	June 17th	
	Aug 19th	Sept 16th
	Nov 18th	Dec 16th
Quarterly:	July 15, 2025, 11:30 am	October 21, 2025, 11:30 am

Quality Assurance Meeting
Attendance Sheet
May 22, 2025

RESIDENCES AT VANTAGE POINT
Connection • Community • Columbia

Medical Director: _____

Nursing Home Administrator: _____

Director of Health Services: _____

Social Worker: _____

Dietician: _____

Geriatric Nursing Assistant: _____

Infection Preventionist: _____

Additional Committee Members

Printed Name	**Discipline/Vendor Name**	**Signature**

EXHIBIT 16

6934 Aviation Blvd., Suite N
Glen Burnie, MD 21061

NURSING FACILITY SERVICES AGREEMENT

THIS NURSING FACILITY SERVICES AGREEMENT ("Agreement") is made and entered into this 27th day of June, 2010 (the "Effective Date") by and between SEASONS HOSPICE & PALLIATIVE CARE OF Maryland, LLC ("Hospice") and Vantage House ("Facility").

RECITALS

A. WHEREAS, Hospice operates a licensed hospice program.

B. WHEREAS, Facility is a duly licensed nursing facility that is certified to participate in the Medicare and/or Medicaid programs.

C. WHEREAS, the parties contemplate that from time to time individuals residing in Facility will need hospice care and individuals previously accepted into Hospice will need care in a nursing facility.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions.

(a) "Facility Services" means those personal care and room and board services provided by Facility as specified in the Plan of Care for a Hospice Patient, including but not limited to: (i) providing food, including individualized requests and dietary supplements; (ii) assisting with activities of daily living such as mobility and ambulation, dressing, grooming, bathing, transferring, eating and toileting; (iii) arranging and assisting in socializing activities; (iv) assisting in the administration of medicine; (v) providing and maintaining the cleanliness of Hospice Patient's room; (vi) supervising and assisting in the use of any durable medical equipment and therapies included in the Plan of Care; (vii) providing laundry and personal care supplies; (viii) providing health monitoring of general conditions; (ix) contacting family/legal representative for purposes unrelated to the terminal condition; (x) arranging for the provision of medications not related to the management of the terminal illness; and (xi) providing the usual and customary room furnishings provided to Facility residents, including but not limited to,

beds, linens, lamps and dressers. In the case of Medicaid Eligible Hospice Patients, Facility Services shall include all services outlined in the Medicaid covered services rule, as may be amended from time to time.

(b) "Hospice Patient" means an individual who has elected, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

(c) "Hospice Physician" means a duly licensed doctor of medicine or osteopathy employed or contracted by Hospice who, along with the Hospice Patient's attending physician (if any), is responsible for the palliation and management of a Hospice Patient's terminal illness and related conditions.

(d) "Hospice Services" means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include: (i) nursing care and services by or under the supervision of a registered nurse; (ii) medical social services provided by a qualified social worker under the direction of a physician; (iii) physician services to the extent that these services are not provided by the attending physician; (iv) counseling services, including bereavement, dietary and spiritual counseling; (v) physical, respiratory, occupational and speech therapy services; (vi) home health aide/homemaker services; (vii) medical supplies; (viii) drugs and biologicals; (ix) use of medical appliances; and (x) medical direction and management of Hospice Patient.

(e) "Interdisciplinary Group" ("IDG") means a group of qualified individuals, including but not limited to: a doctor of medicine or osteopathy; a registered nurse; a social worker; and a pastoral or other counselor.

(f) "Medicaid Eligible Hospice Patient" means a Hospice Patient who either: is eligible for Medicaid benefits and who has elected to receive the Medicaid hospice benefit; or is eligible for both Medicaid and Medicare Part A benefits and who has elected the Medicare hospice benefit.

(g) "Medicare Eligible Hospice Patient" means a Hospice Patient who is eligible for Medicare Part A benefits, but who is not eligible for Medicaid benefits and who has elected to receive the Medicare Part A hospice benefit.

(h) "Other Facility Services" means all items and services provided by Facility which are not related to treatment of a Hospice Patient's terminal illness but specified in the Plan of Care.

(i) "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the IDG. The Plan of Care must reflect Hospice Patient and family goals and interventions based on the problems identified in the Hospice Patient assessments. The Plan of Care will reflect the participation of the Hospice, Facility and the Hospice Patient and family to the extent possible. Specifically, the Plan of Care includes: (i) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet such Hospice Patient's needs and the related needs of Hospice Patient's family; (ii) a detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated from implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice Patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice Patient; and (vi) the IDG's documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with the Plan of Care. Hospice and Facility will jointly develop and agree upon a coordinated, interdisciplinary Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice Patient and his or her expressed desire for hospice care. Hospice and Facility shall periodically conduct joint reviews of each Plan of Care as necessary to coordinate provision of Facility Services. The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.

(j) "Private Pay Hospice Patient" means a Hospice Patient who is not eligible for the Medicare Part A hospice benefit, or the Medicaid hospice benefit, or if eligible, has revoked or elected not to receive the Medicare Part A hospice benefit and/or the Medicaid hospice benefit. This includes Hospice Patients with third party payors other than Medicare or Medicaid.

(k) "Purchased Hospice Services" means those Hospice Services specified in Exhibit A that are not core services under the Medicare Conditions of Participation for Hospice Care and that Hospice has elected to contract with Facility to provide.

(l) "Residential Hospice Care Day" means a day on which a Hospice Patient receives Facility Services, including the day of admission but excluding the day of discharge and any days on which a Hospice Patient receives inpatient care.

(m) "Uncovered Items and Services" means those services provided by Facility which are not Hospice Services, Facility Services or Other Facility Services, including, but not limited to, telephone, guest trays and television hookup.

2. Responsibilities of Facility.

(a) Provision of Services.

(i) Facility Services. At the request of an authorized Hospice staff member, Facility shall admit Hospice Patients to Facility, subject to Facility's admission policies and procedures and the availability of beds. Facility shall immediately notify Hospice if Facility is unable to admit a Hospice Patient. Facility shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to, accident, injury and infection. Facility's primary responsibility is to provide Facility Services. It is Facility's responsibility to provide Facility Services that meet the personal care and nursing needs that would have been provided by a Hospice Patient's primary caregiver at home, and Facility shall perform Facility Services at the same level of care provided to each Hospice Patient before hospice care was elected. While Facility's nursing personnel may assist in administering prescribed therapies to Hospice Patients under the Plan of Care, such assistance may only be provided to the extent the activity is permitted by law and only to the extent that Hospice would routinely utilize the services of a Hospice Patient's family in implementing the Plan of Care. Notwithstanding the foregoing, in times of Hospice Patient crisis Hospice may authorize and direct Facility staff to perform more sophisticated functions in order to ensure Hospice Patient comfort, and Hospice and Facility shall address potential crisis situations for individual Hospice Patient's in the Plan of Care.

(ii) Availability. Facility shall be available to provide Facility Services 24 hours per day, 7 days per week and shall maintain sufficient personnel who have the requisite training, skills and experience to meet this obligation.

(iii) Purchased Hospice Services. At the request of an authorized Hospice staff member, Facility shall provide Hospice Patients with the Purchased Hospice Services identified in Exhibit A.

(iv) Notification of Services. Facility shall fully inform Hospice Patients of Facility Services, Other Facility Services and Uncovered Items and Services to be provided by Facility.

(b) Professional Standards and Credentials.

(i) Professional Standards. Facility shall ensure that all Facility Services are provided competently and efficiently. Facility Services shall meet or exceed the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements.

(ii) Credentials.

[a] Licensure. Facility represents and warrants that it has and will maintain in good standing during the term of this Agreement all federal, state and local licenses and certificates required by law to provide Facility Services. Upon Hospice's request, Facility shall provide Hospice with evidence of such licenses and certifications.

[b] Qualifications of Personnel. Personnel who provide Facility Services shall be reasonably acceptable to Hospice. Facility represents and warrants that personnel providing Facility Services: [i] are duly licensed, credentialed, certified, and/or registered as required under applicable state laws; and [ii] possess the education, skills, training and other qualifications necessary to provide Facility Services. Based on criminal background checks conducted by Facility, Facility personnel who have direct contact with Hospice Patients or have access to Hospice Patient records have not been found to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals. Upon Hospice's request, Facility shall provide Hospice with proof of an individual's qualifications to provide Facility Services.

[c] Disciplinary Action. Facility represents and warrants that neither it nor any of its personnel is under suspension or subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Facility or its personnel and is not under any formal or informal investigation or preliminary inquiry by such department or agency for possible disciplinary action.

[d] Exclusion from Medicare or Medicaid. Facility represents and warrants that neither Facility nor its personnel has been, at any time, excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid, nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration law.

(c) Quality Assessment and Performance Improvement Activities. Facility shall cooperate with Hospice in its hospice-wide quality assessment and performance improvement activities. Components of the quality assessment and performance improvement program include (i) data collection; (ii) reporting adverse patient events, analyzing their causes, and implementing preventative actions and mechanisms; and (iii) taking actions to improve performance. Hospice shall provide Facility with a description of its quality assessment and performance improvement program and information on performance improvement projects. Third party payors may also impose their own utilization management or quality assurance requirements which Facility must meet. Cooperating in such activities shall not constitute a waiver of any legal privileges or rights that may apply to the information that is shared. Hospice shall maintain the confidentiality of such information in whatever form it is provided.

(d) Coordination of Care.

(i) General. Facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Facility Services. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.

(ii) Design of Plan of Care. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for development of the Plan of Care.

(iii) Modifications to Plan of Care. Facility will assist with periodic review and modification of the Plan of Care. Facility will not make any modifications to the Plan of Care without first consulting with Hospice. Hospice retains the sole authority for determining the appropriate level of hospice care provided to each Hospice Patient.

(iv) Notification of Change in Condition. Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient. This includes, without limitation, a significant change in a Hospice Patient's physical, mental, social or emotional status, clinical complications that suggest a need to alter the Plan of Care, a need to transfer the Hospice Patient to another facility, or the death of a Hospice Patient.

(e) Policies and Procedures. In providing services to Hospice Patients, Facility shall abide by Hospice's policies and procedures, palliative care protocols and Plans of Care.

(f) Assist with Surveys and Complaints. Facility shall be available during federal, state, local and other surveys to assist Hospice in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing clinical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Hospice, Facility shall fully cooperate with Hospice in an effort to respond to and resolve the same in a timely and effective manner. Facility shall also cooperate fully with any insurance company providing protection to Hospice in connection with investigations. Facility shall notify Hospice promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

(g) Visiting and Access by Hospice.

(i) Visiting Privileges. Facility shall permit free access and unrestricted visiting privileges, including visits by children of any age, 24 hours per day, 7 days per week.

(ii) Visitor Accommodations. Facility shall provide adequate space, located conveniently to Hospice Patient, for private visiting among Hospice Patient, Hospice Patient's family members and any other visitors. Facility shall provide adequate accommodations for Hospice Patient's family members to remain with Hospice Patient up to 24 hours per day, and permit family members privacy following the death of a Hospice Patient.

(iii) Hospice Access to Facility. Facility shall permit employees, contractors, agents and volunteers of Hospice free and complete access to Facility 24 hours per day, as necessary, to permit Hospice to counsel, treat, attend and provide services to each Hospice Patient.

(iv) Hospice Physician. Facility shall grant full staff privileges to Hospice Physicians upon application and qualification for such privileges in accordance with Facility's requirements.

(h) Patient Transfer. Facility shall not transfer any Hospice Patient to another care setting without the prior approval of Hospice. If Facility fails to obtain the necessary prior approval, Hospice bears no financial responsibility for the costs of transfer or the costs of care provided in another setting.

(i) Physician Orders. If there are physician orders that are inconsistent with the Plan of Care or Hospice protocols, a registered nurse with Facility shall notify Hospice. An authorized representative of Hospice shall resolve differences directly with the physician and secure the necessary orders.

(j) Bereavement Services to Facility Staff. Facility shall be primarily responsible for providing and requested bereavement services to Facility staff after the death of a Hospice Patient who resided in Facility; provided, however, that Hospice may assist Facility in providing such bereavement services to grieving Facility staff members upon request from Facility.

3. Responsibilities of Hospice.

(a) Admission to and Discharge from Hospice Program.

(i) Assessment. If a resident of Facility requests the provision of Hospice Services, Hospice shall perform an assessment of such resident and shall notify Facility, either orally or in writing, whether such resident is authorized for admission as a Hospice Patient. Hospice shall maintain adequate records of all such authorizations of admission.

(ii) Assessing Continued Eligibility. Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice.

(b) Professional Management Responsibility.

(i) Compliance with Law. Hospice shall assume professional management responsibility for Hospice Services provided to Hospice Patients residing at Facility and their family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of the Plan of Care, authorization of all services and management of the care through IDG meetings. Hospice shall make arrangement for, and remain responsible for, any necessary continuous care or inpatient care related to a Hospice Patient's terminal illness and related conditions. Hospice acknowledges that it is responsible for providing Hospice Services to Hospice Patients residing at Facility at the same level and to the same extent as if Hospice Patients were receiving care in their own homes.

(ii) Management of Hospice Services. Hospice shall retain professional management responsibility to ensure that Hospice Services are furnished in a safe and effective manner by qualified personnel in accordance with Hospice Patient's Plan of Care.

(iii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Facility Services. Hospice's IDG shall communicate with Facility's medical director, Hospice Patient's attending physician and other physicians participating in the care of a Hospice Patient as needed to coordinate Hospice Services with the medical care provided by other physicians. Methods used to evaluate the care may include: [a] periodic supervisory visits; [b] review of the qualifications of personnel providing Facility Services; [c] review of documentation; [d] evaluation of the response of a Hospice Patient to the Plan of Care; [e] discussion with patient and patient's caregivers; [f] patient evaluation surveys; and [g] quality improvement data.

(iv) Assessment of Facility Services. Hospice shall develop, maintain and conduct an ongoing, comprehensive assessment of the quality and appropriateness of Facility and the provision of Facility Services. Such assessments shall be conducted at least annually.

(c) Hospice Care Training. Hospice may provide orientation and ongoing hospice care training to Facility's personnel as necessary to facilitate the provision of safe and effective care to Hospice Patients. Such orientation must include Hospice policies and procedures regarding methods of comfort, pain control and symptom management as well as principles about death and dying, individual responses to death, patient rights, appropriate forms and recordkeeping requirements.

(d) Designation of Hospice Representative. For each Hospice Patient, Hospice shall designate a registered nurse who will be responsible for coordinating and supervising services provided to a Hospice Patient and be available 24 hours per day, 7 days per week for consultation with Facility concerning a Hospice Patient's Plan of Care. In addition, for each Hospice Patient residing at Facility, Hospice shall designate a member of the Hospice Patient's IDG to provide overall coordination of care for such Hospice Patient. Such hospice representative shall monitor Facility and be available to provide information to Facility regarding the provision of Facility Services and to coordinate the periodic evaluation of patient progress and outcomes of care upon request. Further, the hospice representative shall be responsible for communicating with Facility representatives and other health care providers who participate in the care of a Hospice Patient's terminal illness and related conditions to ensure quality of care for Hospice Patients and their families.

(e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination. At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility:

(i) Plan of Care, Medications and Orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility;

(ii) Election Form. The hospice election form and any advanced directives;

(iii) Certifications. Physician certifications and recertifications of terminal illness;

(iv) Contact Information. Names and contact information for Hospice personnel involved in providing Hospice Services; and

(v) On-Call System. Instructions on how to access Hospice's 24-hour on-call system.

(f) Policies and Procedures. Hospice shall provide Facility with copies of Hospice's policies and procedures applicable to the provision of Facility Services and shall meet with Facility to review such policies and procedures, as necessary.

(g) Physician Orders. All physician orders communicated by Hospice under this Agreement shall be in writing and signed by the applicable attending physician or Hospice Physician; provided, however, that in the case of urgent or emergency circumstances, such orders may be communicated orally by any such persons. Hospice shall maintain adequate records of all physician orders communicated in connection with the Plan of Care.

(h) Purchased Hospice Services. Hospice may purchase from Facility Purchased Hospice Services. The terms of such sale are delineated in Exhibit A.

(i) Notification of Hospice Services. Hospice shall fully inform Hospice Patient of the Hospice Services to be provided by Hospice and Purchased Hospice Services, if any, to be provided by Facility.

(j) Assist with Surveys and Complaints. Hospice shall be available during federal, state, local and other surveys to assist Facility in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing medical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Facility, Hospice shall fully cooperate with Facility in an effort to respond to and resolve the same in a timely and effective manner. Hospice shall also cooperate fully with any insurance company providing protection to Facility in connection with investigations. Hospice shall notify Facility promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

(k) Summary of Hospice's Responsibilities. Exhibit B includes a chart that summarizes some of Hospice's major responsibilities to Hospice Patients under this Agreement. This chart is intended to provide examples of Hospice's responsibilities hereunder and is not exhaustive.

4. Billing and Payment.

(a) Billing and Payment for Facility Services Provided to Medicaid Eligible Hospice Patients.

(i) Rates. Hospice shall pay Facility a fixed payment rate for each Residential Hospice Care Day provided to a Medicaid Eligible Hospice Patient, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. The fixed payment rate shall be one hundred percent (100%) of Facility's then current Medicaid per diem rate that would have been paid by the Medicaid program to Facility if the Medicaid Eligible Hospice Patient had not elected to receive hospice care, less the Medicaid Eligible Hospice Patient's required personal contribution amount, if any. Facility shall accept this rate as payment in full for Facility Services provided to such Medicaid Eligible Hospice Patient and shall not bill the Medicaid Eligible Hospice Patient or his/her family, representatives or any third party payor. Facility shall collect and retain the Medicaid Eligible Hospice Patient's required personal contribution amount, if any.

(ii) Billing and Payment. Within ten (10) calendar days of the end of the month and within at least 30 days of providing Facility Services, Facility shall submit to Hospice an accurate and complete statement of all Facility Services provided to Medicaid Eligible Hospice Patients. The statement shall be in a form acceptable to Hospice and include information usually provided to third party payors to verify the services and charges reflected in the statement. Hospice shall pay Facility within 30 days after Hospice's receipt of payment from Medicaid for Facility Services. Payment by Hospice in respect to such bills shall be considered final, unless adjustments are requested in writing by Facility within 30 days of receipt of payment. Hospice shall have no obligation to pay Facility for any service if Hospice does not receive a bill for such service within 120 days following the date on which the service was rendered.

(b) Billing and Payment for Facility Services Provided to Medicare Eligible Hospice Patients and Private Pay Hospice Patients. Facility shall bill each Medicare Eligible Hospice Patient and Private Pay Hospice Patient (or such patient's third party payor, if applicable) for Facility Services at a rate agreed upon by Facility and such patient or his or her third party payor. Facility shall accept such payment as payment in full for Facility Services. Hospice will not be responsible for reimbursing Facility for any portion of the cost of Facility Services provided to a Medicare Eligible Hospice Patient or Private Pay Hospice Patient. Facility shall not seek payment from Hospice in the event of default of financial obligations on the part of a Medicare Eligible Hospice Patient, Private Pay Hospice Patient or such patient's third party payors. Hospice will, to the extent permitted by law, provide Facility with any information it may reasonably require to obtain payment from any payor or other permissible payment source.

(c) Billing and Payment for Purchased Hospice Services Provided to All Hospice Patients. Facility shall bill Hospice for Purchased Hospice Services provided to Hospice Patients at the rates agreed to by Facility and Hospice. Facility represents and warrants that all Purchased Hospice Services for Medicaid Eligible Hospice Patients are not included in the applicable, then-current Medicaid per diem rate that Facility would have received if the Medicaid Eligible Hospice Patient had not elected to receive Hospice Services. The billing and payment procedures set forth in section 4(a)(ii) of this Agreement shall apply.

(d) Billing and Payment for Other Services. Facility shall bill Hospice Patients or the third party payor, if applicable, for (i) Other Facility Services; (ii) Uncovered Items and Services; and (iii) care provided by Facility upon the request of a Hospice Patient which is not reasonable or necessary for palliation or management of the terminal illness and not rendered in accordance with the applicable Plan of Care. Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for the cost of these services.

(e) Limitation on Hospice's Financial Responsibility. Except as specifically identified in this Agreement, Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for any charges, costs, expenses or other fees for services provided under this Agreement.

5. Insurance and Hold Harmless.

(a) Insurance. Each party shall obtain and maintain appropriate professional liability, commercial general liability, worker's compensation and employer's liability insurance coverage in accordance with the minimum amounts required from time to time by applicable federal and state laws and regulations, but at no time shall the terms or coverage amounts of Facility's professional liability insurance be less than $1 million per claim and $3 million in the aggregate. Either party may request evidence of insurance from the other party and such other party shall provide such evidence to the requesting party in a timely manner. Each party shall ensure that the other party receives at least 30 days' notice prior to the termination of any insurance policy required by this Agreement.

(b) Mutual Hold Harmless. Each party shall be responsible for the acts and omissions of itself and its employees and subcontractors and neither party agrees to indemnify any other party for any such act or omission, provided, however, that this Agreement shall not constitute a waiver by any party of any rights to indemnification, contribution or subrogation which such party may have by operation of law.

6. Records.

(a) Creation and Maintenance of Records. Each party shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Facility Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines. Each party shall retain such records for a minimum of six years from the date of discharge of each Hospice Patient or such other time period as required by applicable federal and state law. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party. Facility shall cause each entry made for Facility Services provided to be signed and dated by the person providing Facility Services.

(b) Financial Recordkeeping. Facility shall keep accurate books of accounts and records covering all transactions relating to this Agreement (the "Financial Records") at its principal place of business. Hospice and its duly authorized representatives, including any such independent public accountant or other auditor, shall have the right during regular business hours and on reasonable written notice to Facility to examine Facility's Financial Records and to make copies thereof.

(c) Access by Hospice. Facility shall permit Hospice or its authorized representative, upon reasonable notice, to review and make photocopies of records maintained by Facility relating to the provision of Facility Services, including but not limited to, clinical records and billing and payment records. This section shall survive the termination of this Agreement.

(d) Inspection by Government. In accordance with 42 U.S.C. § 1395x(v)(1)(i) and 42 C.F.R. § 420.300, et seq., Facility shall make available, until the expiration of five years from the termination of this Agreement, upon written request, to the Secretary of Health and Human Services of the United States, and upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any of its books, documents and records that are necessary to certify the nature and costs of Medicare reimbursable services provided under this Agreement. If and to the extent Facility carries out any of its duties under this Agreement through a subcontract with a related organization having a value or cost of $10,000 or more over a 12-month period, then Facility shall ensure that the subcontract contains a clause comparable to the clause in the preceding sentence. Nothing contained in this section shall be construed as a waiver by either party of any legal rights of confidentiality with respect to patient records and proprietary information.

(e) Destruction of Records. Facility shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure.

7. Confidentiality. Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice Patients (collectively, "Patient Information") and may be required to disclose certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be entitled to injunctive relief to prevent a breach or threatened breach of this section, in addition to all other remedies that may be available. This section shall survive termination of this Agreement.

8. Term and Termination.

(a) Term. This Agreement shall have an initial term of one year beginning on the Effective Date ("Initial Term") and shall automatically renew for successive one-year terms, unless sooner terminated as provided below.

(b) Termination.

(i) Without Cause. This Agreement may be terminated by either party for any reason after the Initial Term by providing at least 60 days' prior written notice to the other party.

(ii) Mutual Written Agreement. This Agreement may terminate at any time after the Initial Term upon written agreement of the parties.

(iii) For Cause. Either party may terminate this Agreement upon 30 days' prior written notice to the other party, if the other party breaches this Agreement and fails to cure such breach within a 10-day period.

(iv) Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 60 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing at least 30 days' notice to the other party.

(v) Immediate Termination. Notwithstanding the above, either party may immediately terminate this Agreement if:

[a] Failure to Have Qualifications. A party or its personnel are excluded from any federal health program or no longer have the necessary qualifications, certifications and/or licenses required by federal, state and/or local laws to provide Facility Services.

[b] Liquidation. A party commences or has commenced against it proceedings to liquidate, wind up, reorganize or seek protection, relief or a consolidation of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

[c] Failure to Have Insurance. A party ceases to have any of the insurance required under this Agreement.

[d] Threats to Health, Safety or Welfare. A party fails to perform its duties under this Agreement and the other party determines in its full discretion that such failure threatens the health, safety or welfare of any patient.

[e] Commission of Misconduct. A party commits an act of misconduct, fraud, dishonesty, misrepresentation or moral turpitude involving the other party or a mutual patient of the parties.

(c) Effect of Termination on Availability of Facility Services. In the event this Agreement is terminated, Facility shall work with Hospice in coordinating the continuation of Facility Services to existing Hospice Patients and shall continue to provide Facility Services to Hospice Patients after this Agreement is terminated, if Hospice determines that removing Facility Services would be detrimental to Hospice Patients. In such cases, Facility Services shall continue to be provided in accordance with the terms set forth in this Agreement. This section shall survive termination of this Agreement.

9. Notification of Material Events. Either party shall immediately notify the other party of:

(a) Business Address Change. Any change in business address.

(b) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against the party or its personnel.

(c) Exclusion. Any threatened, proposed or actual exclusion of it or any of its subcontractors or personnel from any government program, including but not limited to, Medicare or Medicaid.

(d) Insurance. The cancellation or modification of any of the insurance coverage that the party is required to have under this Agreement.

(e) Liquidation. The commencement of any proceeding to liquidate, wind up, reorganize or seek protection, relief or a consolidation of Facility's or Hospice's debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

(f) Incident Reporting. Any of the following alleged incidents involving a Hospice Patient residing at Facility:

(i) mistreatment or neglect;

(ii) verbal, mental, sexual or physical abuse;

(iii) injuries or an unknown source; or

(iv) misappropriation of patient property.

10. Nondiscrimination. The parties agree that in the performance of this Agreement they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion, disability, national origin or any other protected class in any manner prohibited by federal or state laws.

11. Independent Contractor. In performance of the services discussed herein, Hospice and Facility shall each be, and at all times are, acting and performing as an independent contractor, and not as a partner, a co-venturer, an employee, an agent or a representative of the other. No employee or agent of one party to this Agreement shall be considered an employee or agent of the other party.

12. Use of Name or Marks. Neither Hospice nor Facility shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party; provided, however, that one party may use the name, symbols, or marks of the other party in written materials previously approved by the other party for the purpose of informing prospective Hospice Patients and attending physicians of the availability of the services described in this Agreement.

13. Miscellaneous Provisions.

(a) Amendment. No amendment, modification or discharge of this Agreement, and no waiver hereunder, shall be valid or binding unless set forth in writing and duly executed by the parties hereto.

(b) Severability. This Agreement is severable, and in the event that any one or more of the provisions hereof shall be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

(c) Headings. The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

(d) Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Maryland. Any claims or disputes related to this Agreement shall be brought in Baltimore, Maryland.

(e) Nonassignability. Neither party shall assign or transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other party, and any assignment or transfer without such consent shall be null and void.

(f) Waiver. The waiver by either party of a breach or violation of any provision in this Agreement shall not operate or be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights or privileges hereunder.

(g) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns. There are no third party beneficiaries of or to this Agreement.

(h) No Third Party Beneficiaries. Except as expressly provided elsewhere herein, nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party.

(i) Force Majeure. In the event that either party's business or operations are substantially interrupted by acts of war, fire, labor strike, insurrection, riots, earthquakes or other acts of nature of any cause that is not the party's fault or is beyond that party's reasonable control, then that party shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

(j) No Requirement to Refer. This Agreement is not intended to influence the judgment of any physician or provider in choosing medical specialists or medical facilities appropriate for the proper care and treatment of residents. Neither Facility nor Hospice shall receive any compensation or remuneration for referrals.

(k) Nonexclusive Agreement. This Agreement is intended to be nonexclusive, and either party may use any provider for the same or similar services.

(l) Counterparts. This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

(m) Notices. All notices or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement shall be in writing, addressed as set forth below, and shall be mailed by first-class, registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or facsimile. Such notice or other communication shall be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee (with the return receipt, the delivery receipt, the affidavit or messenger or the answer back being deemed conclusive evidence of such delivery) or at such time as delivery is refused by the addressee upon presentation. Each party may designate by notice in writing a new address to which any notice or communication may thereafter be so given, served or sent.

TO: HOSPICE
Seasons Hospice & Palliative Care of Maryland
6934 Aviation Blvd., Suites N-R
Glen Burnie, MD 21061
Attn: Executive Director

TO: FACILITY
Vantage House
5400 Vantage Point Rd.
Columbia, MD 21044
Attn: Chris Newport, Administrator

(n) Entire Agreement. This Agreement, including all of the exhibits and addenda attached hereto, contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understandings between them with respect to the matters provided for herein. This Agreement may not be modified or amended except by mutual consent of the parties, and any such modification or amendment must be in writing duly executed by the parties hereto, and shall be attached to, and become a part of, this Agreement.

The parties have executed this Agreement as of the day, month and year first written above.

Agreed HOSPICE	Agreed HOME
By:	By: Meriann P. Ritacco
Name: Gary Applebaum, MD	Name: MERIANN P. RITACCO
Title: Executive Director	Title: EXECUTIVE DIRECTOR
Seasons Hospice & Palliative Care	VANTAGE HOUSE
Date: 6/27/2010	Date: 07 / 12 /2010

EXHIBIT A
PURCHASED HOSPICE SERVICES

1. Purchased Hospice Services. The following services and items will be purchased, as needed, by Hospice from Facility on the terms set forth in this Exhibit A and elsewhere in the Agreement. The rates identified reflect fair market value, without regard to the volume and value of referrals.

2. Authorized Personnel. The following hospice representatives are authorized to purchase or order items and services from Facility for Hospice Patients.

   Hospice Director of Clinical Services; Team Director; and Executive Director

3. Billing and Payment. Billing and payment for Purchased Hospice Services shall be governed by this Agreement.

4. Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Purchased Hospice Services to ensure the provision of quality care. All Purchased Hospice Services must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care.

EXHIBIT B
SUMMARY OF RESPONSIBILITIES

ROLE	HOSPICE	FACILITY	N/A
Admitting Hospice Patients, Beginning Services	X		
Assessing Hospice Patients, Including Who is Responsible for the Initial and Ongoing Assessment	X		
Identifying the Individual(s) Responsible for the Care Planning Process	X		
Coordinating, Supervising, and Evaluating the Care and Services Provided	X		
Scheduling Visits or Hours	X		
Discharge Planning from Hospice	X		

APPENDIX A
HOSPICE ADMISSION CRITERIA

1. The patient has a terminal prognosis of six months or less as certified by the patient's attending physician and the Hospice physician.

2. The patient or the patient's health care power of attorney (where applicable) elects in writing to receive Hospice services.

3. The patient's attending physician, as named by the patient/family, provides written consent for patient to receive hospice services.

4. The patient/family understands Hospice's concept of care as being palliative and not curative in its goals.

5. The patient/family understands that Hospice retains responsibility for determining the appropriate location or treatment.

6. Race, color, creed, religion, gender, national origin, disability or sexual preference shall not be used as criteria for admission.

7. Final determination of eligibility for admission is made by Hospice.

APPENDIX B
HOSPICE ROUTINE HOME CARE

On the basis of the needs of the patient and family as determined by Hospice and documented in the Patient's Plan of Care (Interdisciplinary Record of Care), the following services related to the management of the terminal illness will be provided to eligible residents:

1. Home visits by registered nurses with 24 hour availability.
2. Home visits by licensed practical nurses or licensed vocational nurses.
3. Home visits by social workers.
4. Home visits by chaplains.
5. Home visits by home health aides or homemakers.
6. Home visits by volunteers.
7. Family counseling services to family members during the time the patient is receiving Hospice care with 24 hour availability.
8. Bereavement care and counseling for family members for as long as one year following the patient's death.
9. Prescription medications, medical supplies and equipment provided directly or under arrangement between Hospice and Facility or others, if related to the patient's terminal illness.
10. Ancillary therapies related to the patient's terminal illness including physical therapy, speech pathology, respiratory therapy, occupational therapy and nutritional counseling.
11. Laboratory services related to the patients terminal illness.
12. Training for Facility's staff in the use of Hospice protocols.
13. Counseling for Facility's staff to deal with personal grief and loss in connection with work with terminally ill patients.

ADDENDUM A
RESPITE CARE

THIS RESPITE CARE ADDENDUM is made and entered into this 27th day of June, 2010 (the "Effective Date") and amends and is made part of the NURSING FACILITY SERVICES AGREEMENT ("Agreement") by and between SEASONS HOSPICE & PALLIATIVE CARE OF Maryland ("Hospice") and Vantage House ("Facility") dated June 27, 2010 (the "Agreement").

RECITAL

Hospice and Facility desire to modify the Agreement to address the provision of Respite Care to Hospice Patients.

AGREEMENTS

1. Definitions. Capitalized terms not otherwise defined in this Addendum shall have the meanings given to them in the Agreement.

(a) "Respite Care" means short-term inpatient care provided to a Hospice Patient when necessary to relieve a Hospice Patient's family members or other persons caring for the patient. Such services include, without limitation, nursing, dietary, housekeeping, therapies, emergency, laboratory, radiology, respiratory, pharmacy, oxygen services and related ancillary services.

(b) "Respite Care Day" means a day on which a Hospice Patient receives Respite Care from Facility, including the day of admission but excluding the day of discharge, unless the patient dies in Facility.

2. Responsibilities of Facility.

(a) Provision of Respite Care. At the request of an authorized Hospice staff member, Facility shall provide Respite Care to Hospice Patients in accordance with Facility's obligations to provide Facility Services to Hospice Patients under the Agreement, except as such obligations are superseded by this Addendum. Facility shall provide Hospice Patients with beds in Facility. While Facility does not guarantee the availability of any specific number of beds, it will make beds available to Hospice Patients on the same priority basis as its other patients.

(b) Medicare or Medicaid Certification. Facility represents and warrants that it is currently, and will at all times during the term of this Addendum remain, certified to participate in the Medicare and/or Medicaid programs.

(c) Twenty-Four Hour Nursing Services. Facility shall provide 24-hour nursing services that meet the nursing needs of all Hospice Patients and are furnished in accordance with each patient's Plan of Care. Each Hospice Patient must receive all nursing services as prescribed. For each shift, Facility will identify to Hospice in advance a charge nurse or other member of Facility's nursing staff who will respond to Hospice's requests for information concerning Hospice Patients.

(d) Home-Like Atmosphere. Facility shall provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients.

(e) Discharge Summary. Facility shall provide Hospice with a copy of the discharge summary at the time of discharge.

(f) Inpatient Clinical Record. Facility shall maintain an inpatient clinical record for each Hospice Patient that includes a record of all Respite Care furnished and events regarding care that occurred at Facility. A copy of the inpatient clinical record shall be available to Hospice at the time of discharge.

(g) Implementation of Agreement. Facility shall designate an individual within the facility who shall be responsible for the implementation of the provisions of this Addendum and the Agreement ("Responsible Facility Representative"). The current Responsible Facility Representative is identified at the end of this Addendum. Facility shall notify Hospice if a new individual is designated as the Responsible Facility Representative.

3. Hospice Responsibilities.

(a) Provision of Plan of Care to Facility. Upon a Hospice Patient's admission to Facility for Respite Care, Hospice shall furnish a copy of the current Plan Care. Hospice shall specify the Respite Care to be furnished by Facility to such Hospice Patient.

(b) Verification of Regulatory Requirements. Hospice shall verify compliance the following requirements established by the Medicare Conditions of Participation for Hospice Care.

(i) Copy of Plan of Care. Hospice shall document in the patient's record that the Plan of Care has been provided to Facility and specify the Respite Care that Facility will furnish. Hospice shall periodically review Hospice Patients' records to verify that these requirements are met.

(ii) Patient Care Policies. Hospice shall verify that Facility has established patient care policies that are consistent with Hospice's policies and agrees to abide by the palliative care protocols and Plans of Care established by Hospice for its

patients. Hospice shall review Facility's policies to determine their consistency with Hospice policies.

(iii) Inpatient Clinical Records. Hospice shall periodically review Hospice Patients' inpatient clinical records to determine that they include a record of all Respite Care furnished and events regarding care that occurred at Facility. Facility shall make inpatient clinical records available to Hospice at the time of discharge.

(iv) Copy of Discharge Summary. Hospice shall document in the patient's record that Facility provided a copy of the discharge summary at the time of discharge. Hospice shall periodically review Hospice Patients' records to verify that this requirement is met.

(v) Responsible Facility Representative. The Responsible Facility Representative is identified at the end of this Addendum. Facility shall immediately notify Hospice if a new Responsible Facility Representative is appointed, and shall inform Hospice of the name and contact information of the new Responsible Facility Representative. Hospice shall maintain a record of Responsible Facility Representatives.

(vi) Hospice Training. Facility shall provide Hospice with a list of Facility personnel who will be providing Respite Care to Hospice Patients, indicating whether each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide Hospice with the names of the individuals who gave the training and a description of the training. For personnel who have not received hospice training, Hospice shall provide training, and shall document the names of the individuals who gave the training and a description of the training. Upon hiring new personnel who will be providing care to Hospice Patients, Facility shall notify Hospice and indicate whether the personnel have received hospice training and, if so, the names of the individuals who gave the training and a description of the training.

(vii) Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Respite Care to ensure the provision of quality care. All Respite Care must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care. Facility is authorized to provide all Respite Care identified in the Plan of Care. Facility shall seek authorization from designated Hospice personnel prior to providing Respite Care not identified in the Plan of Care.

4. Billing and Payment.

(a) Medicaid Eligible Hospice Patients, Medicare Eligible Hospice Patients and Private Pay Hospice Patients. For each Respite Care Day provided to a Medicaid Eligible Hospice Patient or a Medicare Eligible Hospice Patient, Hospice shall pay Facility a fixed payment equal to 100% of the Medicare or Medicaid allowable rate,

except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. Rates for reimbursement for Respite Care Days provided to Private Pay Hospice Patients, including those with third party payors other than Medicare or Medicaid, will be established in writing in advance for each such patient.

(b) Billing. The terms for billing for Respite Care shall be governed by the Agreement.

5. Responsible Facility Representative. Facility has identified the following individual as the Responsible Facility Representative: MERIANN RITACCO.

6. Conflicts. This Addendum shall be subject to the terms and conditions of the Agreement; provided that, in the event of a conflict between the terms and conditions of this Addendum and the terms and conditions of the Agreement, the terms and conditions of this Addendum shall control. Except as specifically amended herein, all other terms and conditions of the Agreement shall remain in full force and effect.

The parties have executed this Addendum as of the day, month and year first written above.

Agreed HOSPICE	**Agreed HOME**
By:	By: Meriann P Ritacco
Name: Gary Applebaum MD	Name: MERIANN P RITACCO
Title: Executive Director	Title: EXECUTIVE DIRECTOR
Seasons Hospice & Palliative Care	VANTAGE HOUSE
Date: 6/27/2010	Date: 07 / 12 /2010

ADDENDUM B
GENERAL INPATIENT SERVICES

THIS INPATIENT CARE ADDENDUM is made and entered into this 27th day of June, 2010 (the "Effective Date") and amends and is made part of the NURSING FACILITY SERVICES AGREEMENT ("Agreement") by and between SEASONS HOSPICE & PALLIATIVE CARE OF Maryland ("Hospice") and Vantage House ("Facility") dated June 27, 2010 (the "Agreement").

RECITAL

Hospice and Facility desire to modify the Agreement to address the provision of Inpatient Services to Hospice Patients.

AGREEMENTS

1. Definitions. Capitalized terms not otherwise defined in this Addendum shall have the meanings given to them in the Agreement.

(a) "General Inpatient Care Day" means a day on which a Hospice Patient receives Inpatient Services for pain control or symptom management which cannot be managed in other settings. Any portion of a 24 hour period, if less than 24 hours, shall constitute a General Inpatient Care Day and shall be compensated pursuant to this Agreement, except the day on which the Hospice Patient is discharged unless such patient dies as an inpatient.

(b) "Inpatient Services" means inpatient beds and related services that are available at, and provided by, Facility pursuant to its customary policies, including services necessary for pain control, or for symptom management. Such services include, without limitation, nursing, dietary, housekeeping, therapies, emergency, laboratory, radiology, respiratory, pharmacy, oxygen services and related ancillary services.

2. Responsibilities of Facility.

(a) Provision of Inpatient Services. At the request of an authorized Hospice staff member, Facility shall provide Inpatient Services to Hospice Patients in accordance with Facility's obligations to provide Facility Services to Hospice Patients under the Agreement, except as such obligations are superseded by this Addendum. Facility shall provide Hospice Patients with beds in Facility. While Facility does not guarantee the availability of any specific number of beds, it will make beds available to Hospice Patients on the same priority basis as its other patients.

(b) Medicare Certification. Facility represents and warrants that it is currently, and will at all times during the term of this Addendum remain, certified to participate in the Medicare program.

(c) Twenty-Four Hour Nursing Services. Facility shall provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's Plan of Care, and each shift shall include a registered nurse who provides direct patient care. For each shift, Facility will identify to Hospice in advance a charge nurse or other member of Facility's nursing staff who will respond to Hospice's requests for information concerning Hospice Patients.

(d) Home-Like Atmosphere. Facility shall provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients.

(e) Discharge Summary. Facility shall provide Hospice with a copy of the discharge summary at the time of discharge.

(f) Inpatient Clinical Record. Facility shall maintain an inpatient clinical record for each Hospice Patient that includes a record of all Inpatient Services furnished and events regarding care that occurred at Facility. A copy of the inpatient clinical record shall be available to Hospice at the time of discharge.

(g) Implementation of Agreement. Facility shall designate an individual within the facility who shall be responsible for the implementation of the provisions of this Addendum and the Agreement ("Responsible Facility Representative"). The current Responsible Facility Representative is identified at the end of this Addendum. Facility shall notify Hospice if a new individual is designated as the Responsible Facility Representative.

3. Hospice Responsibilities.

(a) Provision of Plan of Care to Facility. Upon a Hospice Patient's admission to Facility for Inpatient Services, Hospice shall furnish a copy of the current Plan Care. Hospice shall specify the Inpatient Services to be furnished by Facility to such Hospice Patient.

(b) Verification of Regulatory Requirements. Hospice shall verify compliance the following requirements established by the Medicare Conditions of Participation for Hospice Care.

(i) Copy of Plan of Care. Hospice shall document in the patient's record that the Plan of Care has been provided to Facility and specify the Inpatient Services that Facility will furnish. Hospice shall periodically review Hospice Patients' records to verify that these requirements are met.

(ii) Patient Care Policies. Hospice shall verify that Facility has established patient care policies that are consistent with Hospice's policies and agrees to abide by the palliative care protocols and Plans of Care established by Hospice for its patients. Hospice shall review Facility's policies to determine their consistency with Hospice policies.

(iii) Inpatient Clinical Records. Hospice shall periodically review Hospice Patients' inpatient clinical records to determine that they include a record of all Inpatient Services furnished and events regarding care that occurred at Facility. Facility shall make inpatient clinical records available to Hospice at the time of discharge.

(iv) Copy of Discharge Summary. Hospice shall document in the patient's record that Facility provided a copy of the discharge summary at the time of discharge. Hospice shall periodically review Hospice Patients' records to verify that this requirement is met.

(v) Responsible Facility Representative. The Responsible Facility Representative is identified at the end of this Addendum. Facility shall immediately notify Hospice if a new Responsible Facility Representative is appointed, and shall inform Hospice of the name and contact information of the new Responsible Facility Representative. Hospice shall maintain a record of Responsible Facility Representatives.

(vi) Hospice Training. Facility shall provide Hospice with a list of Facility personnel who will be providing Inpatient Services to Hospice Patients, indicating whether each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide Hospice with the names of the individuals who gave the training and a description of the training. For personnel who have not received hospice training, Hospice shall provide training, and shall document the names of the individuals who gave the training and a description of the training. Upon hiring new personnel who will be providing care to Hospice Patients, Facility shall notify Hospice and indicate whether the personnel have received hospice training and, if so, the names of the individuals who gave the training and a description of the training.

(vii) Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Inpatient Services to ensure the provision of quality care. All Inpatient Services must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care. Facility is authorized to provide all Inpatient Services identified in the Plan of Care. Facility shall seek authorization from designated Hospice personnel prior to providing Inpatient Services not identified in the Plan of Care.

4. Billing and Payment.

(a) Medicaid Eligible Hospice Patients, Medicare Eligible Hospice Patients and Private Pay Hospice Patients. Hospice shall pay Facility a fixed rate for each General Inpatient Care Day provided to a Medicaid Eligible Hospice Patient or a Medicare Eligible Hospice Patient, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. The fixed payment rate shall be $325 for each General Inpatient Care Day provided to such patients. Facility shall accept this rate as payment in full for each General Inpatient Care Day provided to Medicaid Eligible Hospice Patients and Medicare Eligible Hospice Patients and shall not bill such patients, their family, representatives or any third party payor. The rate represents fair market value and does not take into account the volume or value of referrals. Rates for reimbursement for General Inpatient Care Days provided to Private Pay Hospice Patients, including those with third party payors other than Medicare or Medicaid, will be established in writing in advance for each such patient.

(b) Billing. The terms for billing for General Inpatient Care shall be governed by the Agreement.

5. Responsible Facility Representative. Facility has identified the following individual as the Responsible Facility Representative Meriann Ritacco.

6. Conflicts. This Addendum shall be subject to the terms and conditions of the Agreement; provided that, in the event of a conflict between the terms and conditions of this Addendum and the terms and conditions of the Agreement, the terms and conditions of this Addendum shall control. Except as specifically amended herein, all other terms and conditions of the Agreement shall remain in full force and effect.

The parties have executed this Addendum as of the day, month and year first written above.

Agreed HOSPICE	Agreed HOME
By:	By: Meriann L. Ritacco
Name: Gary Applebaum, MD	Name: Meriann P. Ritacco
Title: Executive Director	Title: Executive Director
Seasons Hospice & Palliative Care	Vantage House
Date: 6/27/2010	Date: 07 / 12 /2010

Pierce Carey
Executive Director
Residences at Vantage Point
5400 Vantage Point Rd.
Columbia, MD 21244
CareyP@vantagepointresidences.org
410-992-1101

May 20, 2025

To Whom It May Concern,

On behalf of Residences at Vantage Point, I am writing to affirm our commitment to working collaboratively with Adult Evaluation and Review Services (AERS) to ensure the appropriate and timely placement of individuals in need of skilled nursing care or other supportive services.

Our community recognizes the vital role that AERS plays in assessing the needs of functionally and chronically disabled adults and in supporting efforts to maintain individuals in the least restrictive and most appropriate settings possible. We are fully supportive of the AERS process and will cooperate with team members to facilitate assessments, referrals, and placement decisions that are in the best interest of the individuals served. The contact details for our designated representative are provided below:

Maryland Access Point of Howard County (MAP)
Phone: 410-313-1234 (voice/relay)
Toll-Free: 1-844-627-6465 (844-MAP-LINK)

410-313-6437 or email **askhealth@howardcountymd.gov**.

We look forward to continuing a strong partnership with AERS to support the well-being of our community members.

Sincerely,

Pierce Carey
Executive Director

Pierce Carey

From: Pierce Carey
Sent: Tuesday, May 20, 2025 3:26 PM
To: Bitner, Renee
Subject: RE: your email to health dept

Thank you, Renee. We look forward to working with you in the future.

Best,
Pierce

Pierce Carey
Executive Director
Residences at Vantage Point
5400 Vantage Point Road
Columbia, MD 21044
Main: 410.992.1101
careyp@vantagepointresidences.org
www.VantagePointResidences.org

From: Bitner, Renee <rbitner@howardcountymd.gov>
Sent: Tuesday, May 20, 2025 3:25 PM
To: Pierce Carey <careyp@vantagepointresidences.org>
Subject: Re: your email to health dept

CAUTION - EXTERNAL EMAIL: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

I am the AERS contact person. Email is the best way to reach me.

Renee Bitner

Pronouns: She/Her/Hers

Howard County Health Department

AERS/Nurse Monitoring

8930 Stanford Blvd., Columbia, MD 21045

410.313.6438 phone

410.313.6108 fax

rbitner@howardcountymd.gov

www.hchealth.org

DISCLAIMER: This e-mail is intended only for the individual to whom it is addressed. It may be used only in accordance with applicable laws. If you are not the intended recipient, you are strictly prohibited from reading, disseminating, distributing, or copying this message. If you received this e-mail by mistake, please notify the sender and destroy this e-mail.

From: Pierce Carey <careyp@vantagepointresidences.org>
Sent: Tuesday, May 20, 2025 3:22 PM
To: Bitner, Renee <rbitner@howardcountymd.gov>
Subject: RE: your email to health dept

[Note: This email originated from outside of the organization. Please only click on links or attachments if you know the sender.]

Hi Renee,

Thank you for following up. We are in the process of applying for open CON beds in Howard County. As such, we will be adding Medicaid to our skilled nursing facility for the first time. As part of the application, MHCC has instructed us to reach out to the AERS program to formalize a relationship as we look to admit Medicaid residents. I have added their direction below.

> *An AERS evaluation is done when a new resident/patient enters the nursing home, and there is a positive PASRR screen. RVP will be familiar with the process, it is usually done by the Admissions Office or the Social Worker. I am including the contact information for AERS in Howard County. RVP can provide a letter or email from who they work with at the Howard County Health Department for these evaluations as evidence of compliance with the standard*

In short, we will need a point of contact at the AERS program, so that, if awarded the beds, we could begin a working relationship with the program. Please let me know if you have any questions.

Best,
Pierce

Pierce Carey
Executive Director
Residences at Vantage Point
5400 Vantage Point Road
Columbia, MD 21044
Main: 410.992.1101
careyp@vantagepointresidences.org
www.VantagePointResidences.org

From: Bitner, Renee <rbitner@howardcountymd.gov>
Sent: Tuesday, May 20, 2025 3:18 PM
To: Pierce Carey <careyp@vantagepointresidences.org>
Subject: your email to health dept

CAUTION - EXTERNAL EMAIL: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Good afternoon,

I was told that you reached out to the health dept about a partnership with AERS.

What is it that you are looking for?

Renee

Renee Bitner

Pronouns: She/Her/Hers

Howard County Health Department

AERS/Nurse Monitoring

8930 Stanford Blvd., Columbia, MD 21045

410.313.6438 phone

410.313.6108 fax

rbitner@howardcountymd.gov

www.hchealth.org

DISCLAIMER: This e-mail is intended only for the individual to whom it is addressed. It may be used only in accordance with applicable laws. If you are not the intended recipient, you are strictly prohibited from reading, disseminating, distributing, or copying this message. If you received this e-mail by mistake, please notify the sender and destroy this e-mail.

Most awarded independent senior living company in the history of the J.D. Power U.S. Senior Living Satisfaction Study

#1 in Customer Satisfaction among Independent Senior Living Communities, 6 Years in a row

2023 CREDENTIAL PLATINUM

LGBTQ+ Cultural Competency Training

sagecare

COGS

2022 GOLD MEMBER

RESIDENCES AT VANTAGE POINT

Connection • Community • Columbia

BAYADA®
Home Health Care

Empire Towers
7310 Ritchie Highway # 615
Glen Burnie, MD 21061

410-766-0006
410-766-0048 fax
www.bayada.com

To Whom It May Concern,

Bayada Home Health Care has been in partnership with Vantage Point Community, as the preferred provider of skilled home health services for the residents of Vantage Point. This collaboration ensures seamless access to high-quality home-based care, including skilled nursing, physical therapy, occupational therapy, and speech therapy—all of which are fully covered under health insurance plans.

For anyone who is in a Certificate of Need (CON) bed, Bayada is committed to expanding our collaborative efforts. Together, we will ensure that all residents transitioning from the facility have timely access to appropriate home and community-based services. This alignment will support safe discharges, promote independence, and maintain the high standards of care both organizations uphold.

Through this partnership, our shared goal is to provide continuity of care, enhance patient outcomes, and reduce unnecessary rehospitalizations by delivering medically necessary services in the comfort and familiarity of home. Bayada's experienced clinicians work closely with the Vantage Point care team to ensure residents receive individualized, evidence-based care tailored to their unique recovery goals.

We value our partnership with Vantage Point Community and look forward to advancing our mutual mission of empowering individuals to live safely and comfortably where they most want to be—at home.

Sincerely,

Rob Connolly, PT, DPT
Program Manager
Bayada Home Health Care
P:443-995-5590
F:443-577-4545

Compassion. Excellence. Reliability.

NURSING FACILITY SERVICES AGREEMENT

THIS NURSING FACILITY SERVICES AGREEMENT ("Agreement") is made and entered into this 1st day of November, 2019 (the "Effective Date") by and between **GILCHRIST HOSPICE CARE, INC.** ("Hospice") and **RESIDENCES AT VANTAGE POINT** ("Facility").

RECITALS

A. WHEREAS, Hospice operates a licensed hospice program.

B. WHEREAS, Facility is a duly licensed nursing facility that is certified to participate in the Medicare and/or Medicaid programs.

C. WHEREAS, the parties contemplate that from time to time individuals residing in Facility will need hospice care and individuals previously accepted into Hospice will need care in a nursing facility.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions.

(a) "Facility Services" means those personal care and room and board services provided by Facility as specified in the Plan of Care for a Hospice Patient including, but not limited to: (i) providing food, including individualized requests and dietary supplements; (ii) assisting with activities of daily living such as mobility and ambulation, dressing, grooming, bathing, transferring, eating and toileting; (iii) arranging and assisting in socializing activities; (iv) assisting in the administration of medicine; (v) providing and maintaining the cleanliness of Hospice Patient's room; (vi) supervising and assisting in the use of any durable medical equipment and therapies included in the Plan of Care; (vii) providing laundry and personal care supplies; (viii) providing health monitoring of general conditions; (ix) contacting family/legal representative for purposes unrelated to the terminal condition; (x) arranging for the provision of medications not related to the management of the terminal illness; and (xi) providing the usual and customary room furnishings provided to Facility residents including, but not limited to, beds, linens, lamps and dressers. In the case of Medicaid Eligible Hospice Patients, Facility Services shall include all services outlined in the Medicaid covered services rule, as may be amended from time to time.

(b) "Hospice Patient" means an individual who has elected, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

(c) "Hospice Physician" means a duly licensed doctor of medicine or osteopathy employed or contracted by Hospice who, along with the Hospice Patient's attending physician (if any), is responsible for the palliation and management of a Hospice Patient's terminal illness and related conditions.

(d) "Hospice Services" means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include: (i) nursing care and services by or under the supervision of a registered nurse; (ii) medical social services provided by a qualified social worker under the direction of a physician; (iii) physician services to the extent that these services are not provided by the attending physician; (iv) counseling services, including bereavement, dietary and spiritual counseling; (v) physical, respiratory, occupational and speech therapy services; (vi) home health aide/homemaker services; (vii) medical supplies; (viii) drugs and biologicals; (ix) use of medical appliances; and (x) medical direction and management of the Hospice Patient.

(e) "Interdisciplinary Group" ("IDG") means a group of qualified individuals including, but not limited to: a doctor of medicine or osteopathy; a registered nurse; a social worker; and a pastoral or other counselor.

(f) "Medicaid Eligible Hospice Patient" means a Hospice Patient who either: is eligible for Medicaid benefits and who has elected to receive the Medicaid hospice benefit; or is eligible for both Medicaid and Medicare Part A benefits and who has elected the Medicare hospice benefit.

(g) "Medicare Eligible Hospice Patient" means a Hospice Patient who is eligible for Medicare Part A benefits, but who is not eligible for Medicaid benefits and who has elected to receive the Medicare Part A hospice benefit.

(h) "Other Facility Services" means all items and services provided by Facility, which are not related to treatment of a Hospice Patient's terminal illness but specified in the Plan of Care.

(i) "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the IDG. The Plan of Care must reflect Hospice Patient and family goals and interventions based on the problems identified in the Hospice Patient assessments. The Plan of Care will reflect the participation of the Hospice, Facility and the Hospice Patient and family to the extent possible. Specifically, the Plan of Care includes: (i) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet such Hospice Patient's needs and the related needs of Hospice Patient's family; (ii) a

detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated from implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice Patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice Patient; and (vi) the IDG's documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with the Plan of Care. Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice Patient and his or her expressed desire for hospice care. The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.

(j) "Private Pay Hospice Patient" means a Hospice Patient who is not eligible for the Medicare Part A hospice benefit or the Medicaid hospice benefit, or if eligible, has revoked or elected not to receive the Medicare Part A hospice benefit and/or the Medicaid hospice benefit.

(k) "Residential Hospice Care Day" means a day on which a Hospice Patient receives Facility Services, including the day of admission but excluding the day of discharge and any days on which a Hospice Patient receives inpatient care.

(l) "Uncovered Items and Services" means those services provided by Facility that are not Hospice Services, Facility Services or Other Facility Services including, but not limited to, telephone, guest trays and television hookup.

2. Responsibilities of Facility.

(a) Provision of Services.

(i) Facility Services. At the request of an authorized Hospice staff member, Facility shall admit Hospice Patients to Facility, subject to Facility's admission policies and procedures and the availability of beds. Facility shall immediately notify Hospice if Facility is unable to admit a Hospice Patient. Facility shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to, accident, injury and infection. Facility's primary responsibility is to provide Facility Services. It is Facility's responsibility to provide Facility Services that meet the personal care and nursing needs that would have been provided by a Hospice Patient's primary caregiver at home, and Facility shall perform Facility Services at the same level of care provided to each Hospice Patient before hospice care was elected. While Facility's nursing personnel may, as specified by Facility, assist in administering prescribed therapies to Hospice Patients under the Plan of Care, such assistance may only be provided to the extent the activity is permitted by law and only to the extent that Hospice would routinely utilize the services of a Hospice Patient's family in implementing the Plan of Care. Notwithstanding the foregoing, in times of Hospice Patient crisis Hospice may authorize and direct Facility staff to perform

more sophisticated functions in order to ensure Hospice Patient comfort, and Hospice and Facility shall address potential crisis situations for individual Hospice Patients in the Plan of Care.

(ii) Availability. Facility shall be available to provide Facility Services 24 hours per day, 7 days per week and shall maintain sufficient personnel who have the requisite training, skills and experience to meet this obligation.

(iii) Notification of Services. Facility shall fully inform Hospice Patients of Facility Services, Other Facility Services and Uncovered Items and Services to be provided by Facility.

(b) Professional Standards and Credentials.

(i) Professional Standards. Facility shall ensure that all Facility Services are provided competently and efficiently. Facility Services shall meet or exceed the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements.

(ii) Credentials.

[a] Licensure. Facility represents and warrants that it has and will maintain in good standing during the term of this Agreement all federal, state and local licenses and certificates required by law to provide Facility Services. Upon Hospice's request, Facility shall provide Hospice with evidence of such licenses and certifications.

[b] Qualifications of Personnel. Personnel who provide Facility Services shall be reasonably acceptable to Hospice. Facility represents and warrants that personnel providing Facility Services: [i] are duly licensed, credentialed, certified, and/or registered as required under applicable state laws; and [ii] possess the education, skills, training and other qualifications necessary to provide Facility Services. Based on criminal background checks conducted by Facility, Facility personnel who have direct contact with Hospice Patients or have access to Hospice Patient records have not been found to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals. Upon Hospice's request, Facility shall provide Hospice with proof of an individual's qualifications to provide Facility Services.

[c] Disciplinary Action. Facility represents and warrants that neither it nor any of its personnel is under suspension or subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Facility or its personnel and is not under any formal or informal investigation or preliminary inquiry by such department or agency for possible disciplinary action.

[d] Exclusion from Medicare or Medicaid. Facility represents and warrants that neither Facility nor its personnel has been, at any time,

excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid, nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration law.

(c) Quality Assessment and Performance Improvement Activities. Facility shall cooperate with Hospice in its hospice-wide quality assessment and performance improvement activities. Components of the quality assessment and performance improvement program include (i) data collection; (ii) reporting adverse patient events, analyzing their causes, and implementing preventive actions and mechanisms; and (iii) taking actions to improve performance. Hospice shall provide Facility with a description of its quality assessment and performance improvement program and information on performance improvement projects. Third party payors may also impose their own utilization management or quality assurance requirements, which Facility must meet. Cooperating in such activities shall not constitute a waiver of any legal privileges or rights that may apply to the information that is shared. Hospice shall maintain the confidentiality of such information in whatever form it is provided.

(d) Coordination of Care.

(i) General. Facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Facility Services. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.

(ii) Design of Plan of Care. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for development of the Plan of Care.

(iii) Modifications to Plan of Care. Facility will assist with periodic review and modification of the Plan of Care. Facility will not make any modifications to the Plan of Care without first consulting with Hospice. Hospice retains the sole authority for determining the appropriate level of hospice care provided to each Hospice Patient.

(iv) Notification of Change in Condition. Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient. This includes, without limitation, a significant change in a Hospice Patient's physical, mental, social or emotional status, clinical complications that suggest a need to alter the Plan of Care, a need to transfer the Hospice Patient to another facility, or the death of a Hospice Patient.

(e) Policies and Procedures. In providing services to Hospice Patients, Facility shall abide by Hospice's policies and procedures, palliative care protocols and Plans of Care.

(f) Assist with Surveys and Complaints. Facility shall be available during federal, state, local and other surveys to assist Hospice in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing clinical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Hospice, Facility shall fully cooperate with Hospice in an effort to respond to and resolve the same in a timely and effective manner. Facility shall also cooperate fully with any insurance company providing protection to Hospice in connection with investigations. Facility shall notify Hospice promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto

(g) Visiting and Access by Hospice.

(i) Visiting Privileges. Facility shall permit free access and unrestricted visiting privileges, including visits by children of any age, 24 hours per day, 7 days per week.

(ii) Visitor Accommodations. Facility shall provide adequate space, located conveniently to Hospice Patient, for private visiting among Hospice Patient, Hospice Patient's family members and any other visitors. Facility shall provide adequate accommodations for Hospice Patient's family members to remain with Hospice Patient up to 24 hours per day, and permit family members privacy following the death of a Hospice Patient.

(iii) Hospice Access to Facility. Facility shall permit employees, contractors, agents and volunteers of Hospice free and complete access to Facility 24 hours per day, as necessary, to permit Hospice to counsel, treat, attend and provide services to each Hospice Patient.

(iv) Hospice Physician. Facility shall grant full staff privileges to Hospice Physicians upon application and qualification for such privileges in accordance with Facility's requirements.

(h) Patient Transfer. Facility shall not transfer any Hospice Patient to another care setting without the prior approval of Hospice. If Facility fails to obtain the necessary prior approval, Hospice bears no financial responsibility for the costs of transfer or the costs of care provided in another setting.

(i) Physician Orders. If there are physician orders that are inconsistent with the Plan of Care or Hospice protocols, a registered nurse with Facility shall notify Hospice. An authorized representative of Hospice shall resolve differences directly with the physician and secure the necessary orders.

(j) Bereavement Services to Facility Staff. Facility shall be primarily responsible for providing any requested bereavement services to Facility staff after the

death of a Hospice Patient who resided in Facility; provided, however, that Hospice may assist Facility in providing such bereavement services to grieving Facility staff members upon request from Facility.

3. Responsibilities of Hospice.

(a) Admission to and Discharge from Hospice Program.

(i) Assessment. If a resident of Facility requests the provision of Hospice Services, Hospice shall perform an assessment of such resident and shall notify Facility, either orally or in writing, whether such resident is authorized for admission as a Hospice Patient. Hospice shall maintain adequate records of all such authorizations of admission.

(ii) Assessing Continued Eligibility. Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice.

(b) Professional Management Responsibility.

(i) Compliance with Law. Hospice shall assume professional management responsibility for Hospice Services provided to Hospice Patients residing at Facility and their family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of the Plan of Care, authorization of all services and management of the care through IDG meetings. Hospice shall make arrangements for, and remain responsible for; any necessary continuous care or inpatient care related to a Hospice Patient's terminal illness and related conditions. Hospice acknowledges that it is responsible for providing Hospice Services to Hospice Patients residing at Facility at the same level and to the same extent as if Hospice Patients were receiving care in their own homes.

(ii) Management of Hospice Services. Hospice shall retain professional management responsibility to ensure that Hospice Services are furnished in a safe and effective manner by qualified personnel in accordance with Hospice Patient's Plan of Care

(iii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Facility Services. Hospice's IDG shall communicate with Facility's medical director, Hospice Patient's attending physician and other physicians participating in the care of a Hospice Patient as needed to coordinate Hospice Services with the medical care provided by other physicians. Methods used to evaluate the care may include: [a] periodic supervisory visits; [b] review of the qualifications of personnel providing Facility Services; [c] review of documentation: [d] evaluation of the response of a Hospice

Patient to the Plan of Care; [e] discussion with patient and patient's caregivers; [f] patient evaluation surveys; and [g] quality improvement data.

(iv) Assessment of Facility Services. Hospice shall develop, maintain and conduct an ongoing, comprehensive assessment of the quality and appropriateness of Facility and the provision of Facility Services. Such assessments shall be conducted at least annually.

(c) Hospice Care Training. Hospice shall provide orientation and ongoing hospice care training to Facility's personnel as necessary to facilitate the provision of safe and effective care to Hospice Patients. Such orientation must include Hospice policies and procedures regarding methods of comfort, pain control and symptom management as well as principles about death and dying, individual responses to death, patient rights, appropriate forms and recordkeeping requirements.

(d) Designation of Hospice Representative. For each Hospice Patient, Hospice shall designate a registered nurse who will be responsible for coordinating and supervising services provided to a Hospice Patient and be available 24 hours per day, 7 days per week for consultation with Facility concerning a Hospice Patient's Plan of Care. In addition, for each Hospice Patient residing at Facility, Hospice shall designate a member of the Hospice Patient's IDG to provide overall coordination of care for such Hospice Patient. Such hospice representative shall monitor Facility and be available to provide information to Facility regarding the provision of Facility Services and to coordinate the periodic evaluation of patient progress and outcomes of care upon request. Further, the hospice representative shall be responsible for communicating with Facility representatives and other health care providers who participate in the care of a Hospice Patient's terminal illness and related conditions to ensure quality of care for Hospice Patients and their families.

(e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, and treatment planning and care coordination. At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility:

(i) Plan of Care, Medications and Orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility;

(ii) Election Form. The hospice election form and any advanced directives;

(iii) Certifications. Physician certifications and recertifications of terminal illness;

(iv) Contact Information. Names and contact information for Hospice personnel involved in providing Hospice Services; and

(v) On-Call System. Instructions on how to access Hospice's 24-hour on-call system.

(f) Policies and Procedures. Hospice shall provide Facility with copies of applicable Hospice policies and procedures and shall meet with Facility to review such policies and procedures, as necessary.

(g) Physician Orders. All physician orders communicated by Hospice under this Agreement shall be in writing and signed by the applicable attending physician or Hospice Physician; provided, however, that in the case of urgent or emergency circumstances, such orders may be communicated orally by any such persons. Hospice shall maintain records of all physician orders communicated in connection with the Plan of Care.

(h) Notification of Hospice Services. Hospice shall fully inform Hospice Patient of the Hospice Services to be provided by Hospice and Purchased Hospice Services, if any, to be provided by Facility.

(i) Assist with Surveys and Complaints. Hospice shall be available during federal, state, local and other surveys to assist Facility in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing medical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Facility, Hospice shall fully cooperate with Facility in an effort to respond to and resolve the same in a timely and effective manner. Hospice shall also cooperate fully with any insurance company providing protection to Facility in connection with investigations. Hospice shall notify Facility promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

4. Billing and Payment.

(a) Billing and Payment for Facility Services Provided to Medicaid Eligible Hospice Patients.

(i) Rates. Hospice shall pay Facility a fixed payment rate for each Residential Hospice Care Day provided to a Medicaid Eligible Hospice Patient, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. The fixed payment rate shall be 100 percent (100%) of Facility's then current Medicaid per diem rate that would have been paid by the Medicaid program to Facility if the Medicaid Eligible Hospice Patient had not elected to receive hospice care, less the Medicaid Eligible Hospice Patient's required personal contribution amount, if any. Facility shall accept this rate as payment in full for Facility Services

provided to such Medicaid Eligible Hospice Patient and shall not bill the Medicaid Eligible Hospice Patient or his/her family, representatives or any third party payor. Facility shall collect and retain the Medicaid Eligible Hospice Patient's required personal contribution amount, if any.

(ii) Billing and Payment. Within ten (10) calendar days of the end of the month and within at least 30 days of providing Facility Services, Facility shall submit to Hospice an accurate and complete statement of all Facility Services provided to Medicaid Eligible Hospice Patients. The statement shall be in a form acceptable to Hospice and include information usually provided to third party payors to verify the services and charges reflected in the statement. Hospice shall pay Facility within 30 days after receipt of a complete statement. Payment by Hospice in respect to such bills shall be considered final, unless adjustments are requested in writing by Facility within 30 days of receipt of payment. Hospice shall have no obligation to pay Facility for any service if Hospice does not receive a bill for such service within 120 days following the date on which the service was rendered.

(b) Billing and Payment for Facility Services Provided to Medicare Eligible Hospice Patients and Private Pay Hospice Patients. Facility shall bill each Medicare Eligible Hospice Patient and Private Pay Hospice Patient (or such patient's third party payor, if applicable) for Facility Services at a rate agreed upon by Facility and such patient or his or her third party payor. Facility shall accept such payment as payment in full for Facility Services. Hospice will not be responsible for reimbursing Facility for any portion of the cost of Facility Services provided to a Medicare Eligible Hospice Patient or Private Pay Hospice Patient. Facility shall not seek payment from Hospice in the event of default of financial obligations on the part of a Medicare Eligible Hospice Patient, Private Pay Hospice Patient or such patient's third party payors. Hospice will, to the extent permitted by law, provide Facility with any information it may reasonably require to obtain payment from any payor or other permissible payment source.

(c) Billing and Payment for Purchased Hospice Services Provided to All Hospice Patients. Facility shall bill Hospice for Purchased Hospice Services provided to Hospice Patients at the rates agreed to by Facility and Hospice. Facility represents and warrants that all Purchased Hospice Services for Medicaid Eligible Hospice Patients are not included in the applicable, then current Medicaid per diem rate that Facility would have received if the Medicaid Eligible Hospice Patient had not elected to receive Hospice Services. The billing and payment procedures set forth in section 4(a)(ii) of this Agreement shall apply.

(d) Billing and Payment for Other Services. Facility shall bill Hospice Patients or the third party payor, if applicable, for (i) Other Facility Services; (ii) Uncovered Items and Services; and (iii) care provided by Facility upon the request of a Hospice Patient which is not reasonable or necessary for palliation or management of the terminal illness and not rendered in accordance with the applicable Plan of Care.

Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for the cost of these services.

(e) Limitation on Hospice's Financial Responsibility. Except as specifically identified in this Agreement, Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for any charges, costs, expenses or other fees for services provided under this Agreement.

5. Insurance and Hold Harmless.

(a) Insurance. Each party shall obtain and maintain appropriate professional liability, commercial general liability, worker's compensation and employer's liability insurance coverage in accordance with the minimum amounts required from time to time by applicable federal and state laws and regulations, but at no time shall the terms or coverage amounts of Facility's professional liability insurance be less than $1 million per claim and $3 million in the aggregate. Either party may request evidence of insurance from the other party and such other party shall provide such evidence to the requesting party in a timely manner. Facility shall ensure that Hospice receives at least 30 days' notice prior to the termination of any insurance policy required by this Agreement.

(b) Mutual Hold Harmless. Each party shall be responsible for the acts and omissions of itself and its employees and subcontractors and neither party agrees to indemnify any other party for any such act or omission, provided, however, that this Agreement shall not constitute a waiver by any party of any rights to indemnification, contribution or subrogation which such party may have by operation of law.

6. Records.

(a) Creation and Maintenance of Records. Facility shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Facility Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines. Facility shall retain such records for a minimum of ten years from the date of discharge of each Hospice Patient or such other time period as required by applicable federal and state law. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party. Facility shall cause each entry made for Facility Services provided to be signed and dated by the person providing Facility Services.

(b) Financial Recordkeeping. Facility shall keep accurate books of accounts and records covering all transactions relating to this Agreement (the "Financial

Records") at its principal place of business. Hospice and its duly authorized representatives, including any independent public accountant or other auditor, shall have the right during regular business hours and on reasonable written notice to Facility to examine Facility's Financial Records and to make copies thereof.

(c) Access by Hospice. Facility shall permit Hospice or its authorized representative, upon reasonable notice, to review and make photocopies of records maintained by Facility relating to the provision of Facility Services including, but not limited to, clinical records and billing and payment records. This section shall survive the termination of this Agreement.

(d) Inspection by Government. In accordance with 42 U.S.C. § 1395x(v)(1)(i) and 42 C.F.R. § 420.300, et seq., Facility shall make available, until the expiration of five years from the termination of this Agreement, upon written request, to the Secretary of Health and Human Services of the United States, and upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any of its books, documents and records that are necessary to certify the nature and costs of Medicare reimbursable services provided under this Agreement. If and to the extent Facility carries out any of its duties under this Agreement through a subcontract with a related organization having a value or cost of $10,000 or more over a 12-month period, then Facility shall ensure that the subcontract contains a clause comparable to the clause in the preceding sentence. Nothing contained in this section shall be construed as a waiver by either party of any legal rights of confidentiality with respect to patient records and proprietary information.

(e) Destruction of Records. Facility shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure.

7. Confidentiality. Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice Patients (collectively, "Patient Information") and may be required to disclose certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be entitled to injunctive relief to prevent a breach or threatened breach of this section, in addition to all other remedies that may be available. This section shall survive termination of this Agreement.

8. Term and Termination.

(a) Term. This Agreement shall have an initial term of one year beginning on the Effective Date ("Initial Term") and shall automatically renew for successive one-year terms, unless sooner terminated as provided below.

(b) Termination.

(i) Without Cause. This Agreement may be terminated by either party for any reason after the Initial Term by providing at least 90 days' prior written notice to the other party.

(ii) Mutual Written Agreement. This Agreement may terminate at any time after the Initial Term upon written agreement of the parties.

(iii) For Cause. Either party may terminate this Agreement upon 30 days' prior written notice to the other party, if the other party breaches this Agreement and fails to cure such breach within such 30-day period. (iv)

Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 60 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing at least 30 days' notice to the other party.

(v) Immediate Termination. Notwithstanding the above, either party may immediately terminate this Agreement if:

[a] Failure to Have Qualifications. A party or its personnel are excluded from any federal health program or no longer have the necessary qualifications, certifications and/or licenses required by federal, state and/or local laws to provide Facility Services.

[b] Liquidation. A party commences or has commenced against it proceedings to liquidate, wind up, reorganize or seek protection, relief or a consolidation of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

[c] Failure to Have Insurance. A party ceases to have any of the insurance required under this Agreement.

[d] Threats to Health, Safety or Welfare. A party fails to perform its duties under this Agreement and the other party determines in its full discretion that such failure threatens the health, safety or welfare of any patient.

[e] Commission of Misconduct. A party commits an act of misconduct, fraud, dishonesty, misrepresentation or moral turpitude involving the other party or a mutual patient of the parties.

(c) Effect of Termination on Availability of Facility Services. In the event this Agreement is terminated, Facility shall work with Hospice in coordinating the continuation of Facility Services to existing Hospice Patients and shall continue to provide Facility Services to Hospice Patients after this Agreement is terminated, if Hospice determines that removing Facility Services would be detrimental to Hospice Patients. In such cases, Facility Services shall continue to be provided in accordance with the terms set forth in this Agreement. This section shall survive termination of this Agreement.

9. Notification of Material Events. Either party shall immediately notify the other party of:

(a) Ownership Change. Any change in 10% or more of its ownership.

(b) Business Address Change. Any change in business address.

(c) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against the party or its personnel.

(d) Exclusion. Any threatened, proposed or actual exclusion of it or any of its subcontractors or personnel from any government program including, but not limited to, Medicare or Medicaid.

(e) Insurance. The cancellation or modification of any of the insurance coverage that the party is required to have under this Agreement.

(f) Liquidation. The commencement of any proceeding to liquidate, wind up, reorganize or seek protection, relief or a consolidation of Facility's or Hospice's debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

(g) Incident Reporting. Any of the following alleged incidents involving a Hospice Patient residing at Facility:

(i) Mistreatment or neglect;

(ii) Verbal, mental, sexual or physical abuse;

(iii) Injuries of an unknown source; or

(iv) Misappropriation of patient property.

10. Nondiscrimination. The parties agree that in the performance of this Agreement they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion, national origin, or any other protected class in any manner prohibited by federal or state laws.

11. Independent Contractor. In performance of the services discussed herein, Hospice and Facility shall each be, and at all times are, acting and performing as an independent contractor, and not as a partner, a co-venturer, an employee, an agent or a representative of the other. No employee or agent of one party to this Agreement shall be considered an employee or agent of the other party.

12. Use of Name or Marks. Neither Hospice nor Facility shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party; provided, however, that one party may use the name, symbols, or marks of the other party in written materials previously approved by the other party for the purpose of informing prospective Hospice Patients and attending physicians of the availability of the services described in this Agreement.

13. Miscellaneous Provisions

(a) Amendment. No amendment, modification or discharge of this Agreement, and no waiver hereunder, shall be valid or binding unless set forth in writing and duly executed by the parties hereto.

(b) Severability. This Agreement is severable, and in the event that any one or more of the provisions hereof shall be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

(c) Headings. The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

(d) Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Maryland. Any claims or disputes related to this Agreement shall be brought in Baltimore County Circuit Court, Baltimore County, Maryland.

(e) Nonassignability. Neither party shall assign or transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other party, and any assignment or transfer without such consent shall be null and void.

(f) Waiver. The waiver by either party of a breach or violation of any provision in this Agreement shall not operate or be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights or privileges hereunder.

(g) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns. There are no third party beneficiaries of or to this Agreement.

(h) No Third Party Beneficiaries. Except as expressly provided elsewhere herein, nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party.

(i) Force Majeure. In the event that either party's business or operations are substantially interrupted by acts of war, fire, labor strike, insurrection, riots, earthquakes or other acts of nature of any cause that is not that party's fault or is beyond that party's reasonable control, then that party shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

(j) No Requirement to Refer. This Agreement is not intended to influence the judgment of any physician or provider in choosing medical specialists or medical facilities appropriate for the proper care and treatment of residents. Neither Facility nor Hospice shall receive any compensation or remuneration for referrals.

(k) Nonexclusive Agreement. This Agreement is intended to be nonexclusive, and either party may use any provider for the same or similar services.

(l) Counterparts. This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

(m) Notices. All notices or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement shall be in writing, addressed as set forth below, and shall be mailed by first-class, registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or facsimile. Such notice or other communication shall be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee (with the return receipt, the delivery receipt, the affidavit or messenger or the answer back being deemed conclusive evidence of such delivery) or at such time as delivery is refused by the addressee upon presentation. Each party may designate by notice in writing a new address to which any notice or communication may thereafter be so given, served or sent.

TO: HOSPICE
Gilchrist Hospice Care, Inc.
11311 McCormick Rd., Ste. 350
Hunt Valley, MD 21031
Attn: Catherine Y. Hamel, President
FAX No.: 443-849-8284
Medicare Provider No.: 211526

TO: FACILITY
RESIDENCES AT VANTAGE POINT
Attn: Meriann Ritacco, Executive Director
5400 Vantage Point Road
Columbia, MD 21044
FAX No.: 410-992-1304
Medicare Provider No.: 215344

(n) Entire Agreement. This instrument contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understandings between them with respect to the matters provided for herein. This Agreement may not be modified or amended except by mutual consent of the parties, and any such modification or amendment must be in writing duly executed by the parties hereto, and shall be attached to, and become a part of, this Agreement.

The parties have executed this Agreement as of the day, month and year first written above.

HOSPICE:
GILCHRIST HOSPICE CARE, INC.

By: Catherine Y. Hamel
Name: Catherine Y. Hamel
Title: President

FACILITY:
RESIDENCES AT VANTAGE POINT

By: Meriann Ritacco 10/31/19
Name: Meriann Ritacco
Title: Executive Director

PATIENT TRANSFER AGREEMENT
BETWEEN
VANTAGE HOUSE RETIREMENT COMMUNITY
AND
HOWARD COUNTY GENERAL HOSPITAL, INC.

THIS AGREEMENT, made as of this 20th day of December, 2012 by and between **HOWARD COUNTY GENERAL HOSPITAL, INC.** (herein called "Hospital") and **VANTAGE HOUSE RETIREMENT COMMUNITY** (herein called "Facility").

WHEREAS, Hospital and Facility desire, by means of this Agreement, to insure continuity of care and treatment appropriate to the needs of the patients, (hereinafter referred to as "patients") in the Facility and the Hospital, utilizing the knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the health and care of patients.

NOW, THEREFORE, THIS AGREEMENT WITNESSETH: That in consideration of the mutual advantages accruing to the parties hereto, Facility and Hospital hereby covenant and agree with each other as follows:

I. **FACILITY AND HOSPITAL AGREE:**

A. That when a patient's need for transfer from either Facility or Hospital to the other has been determined by the patient's physician, the institution to which transfer is made shall admit the patient as promptly as possible, provided all conditions of eligibility are met.

B. That the transferring party shall send with each patient at the time of transfer an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption and provide essential identifying information.

C. That the transferring party shall obtain the consent for the patient or patient's authorized representative for the transfer.

D. That the transferring party shall arrange for appropriate and safe transportation of patients.

E. That the transferring party shall arrange for appropriate and safe handling of patients' valuables.

G. That the clinical records of a patient transferred shall contain evidence that the patient was transferred.

I. That transfer procedures shall be made known to the patient care personnel

of each of the parties.

J. That neither party shall use the name of the other in any promotional or advertising material without the prior written approval of the other party.

K. That governing bodies of each institution shall have exclusive control of their policies, management, assets and affairs of their respective institutions.

L. That neither party assumes liability for any debts or other obligations for the other party's action.

II. EACH PARTY REPRESENTS AND WARRANTS UPON EXECUTION AND THROUGHOUT THE TERM OF THIS AGREEMENT THAT:

A. In the case of Hospital, it is an acute care hospital licensed by the State of Maryland and accredited by the Joint Commission;

B. In the case of Facility, it is appropriately licensed by the State of Maryland for the level of care it provides;

C. All medical professionals providing services to patients at its institution are licensed in their profession by the State of Maryland and credentialed by Facility or Hospital, as the case may be, and that services provided to patients shall be within the scope of said medical professional's privileges;

D. It shall perform the services required hereunder in accordance with: (I) all applicable federal, state, and local laws, rules and regulations; and all applicable standards of the Joint Commission and any other relevant accrediting organizations;

E. It has, and shall maintain throughout the term of this Agreement, all appropriate federal and state licenses and certifications which are required in order to perform the services required hereunder; and

F. Neither it nor any of its staff is sanctioned or excluded from any federally funded health care programs as provided in Sections 1128 and 1128A of the Social Security Act (42 U.S.C. 1320a-7a).

III. <u>BILLING</u>:

Bills incurred with respect to services performed by the Facility or Hospital for patient care shall be collected by the institution rendering such services directly from the patient, third party insurance coverage, or other sources normally billed by the institution. No clause of this Agreement shall be interpreted to require Facility or

Hospital to compensate the other for services rendered to a patient transferred under this Agreement.

IV. **TERM:**

A. This Agreement shall be effective from 12/20/12 and shall continue in effect indefinitely, except that either party may withdraw by giving sixty (60) days notice period. However, if either party shall breach any of the representations and warranties set forth in Section II, this Agreement shall terminate as of the date of such breach.

V. **GENERAL:**

A. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, and any such modification or amendment shall be attached to and become part of this Agreement.

B. An executed copy of this Agreement with all amendments, if any, shall be kept in the administrative file of each of the parties for reference.

C. Nothing in this Agreement shall be construed as limiting the rights of either party to affiliate or contract with any other facility while this Agreement is in effect.

D. This Agreement is subject to all requirements of Maryland law and any regulations issued pursuant hereto and that where the Agreement is in conflict with the provision of the law or the regulations, the same shall be deemed to conform with the law and the regulations.

E. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by Federal Express or Express Mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to Hospital:

Howard County General Hospital
Attention: President
5755 Cedar Lane
Columbia, Maryland 21044

With a copy to:

The Johns Hopkins Health System Corporation
Attention: General Counsel
733 N. Broadway
Suite 102
Baltimore, Maryland 21205

If to Facility:

Vantage House Retirement Community
Attn: Executive Director
5400 Vantage Point Road
Columbia, Maryland 21044

Or to such other persons as either party may from time to time designate by written notice to the other.

(PAGE INTENTIONALLY LEFT BLANK)

IN WITNESS WHEREOF, Howard County General Hospital and Vantage House have executed this Agreement by their duly authorized representatives.

WITNESS:

HOWARD COUNTY GENERAL HOSPITAL

By: Victor Broccolino
Name: Victor A. Broccolino
Title: President
Date: 12/31/2012

This Agreement has been reviewed for legal sufficiency by The Johns Hopkins Health System Corporation Legal Department.

Paula Grant /per/

WITNESS:

VANTAGE HOUSE RETIREMEN COMMUNITY

By: Miriam P. Rotacco
Name: MIRIAM P. ROTACCO
Title: EXECUTIVE DIRECTOR
Date: 12-20-2012

EXHIBIT 17

COLUMBIA VANTAGE HOUSE CORPORATION

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED JUNE 30, 2024 AND 2023

CPAs | CONSULTANTS | WEALTH ADVISORS

CLAconnect.com

COLUMBIA VANTAGE HOUSE CORPORATION
TABLE OF CONTENTS
YEARS ENDED JUNE 30, 2024 AND 2023

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
Columbia Vantage House Corporation
Columbia, Maryland

Report on the Audit of the Consolidated Financial Statements

Opinion

We have audited the accompanying consolidated financial statements of Columbia Vantage House Corporation and its subsidiary, which comprise the consolidated statements of financial position as of June 30, 2024 and 2023, and the related consolidated statements of operations, changes in net assets (deficiency), and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Columbia Vantage House Corporation and its subsidiary as of June 30, 2024 and 2023, and the results of their operations, changes in net assets (deficiency), and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Columbia Vantage House Corporation and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Columbia Vantage House Corporation's ability to continue as a going concern for one year after the date the consolidated financial statements are available to be issued.

CLA (CliftonLarsonAllen LLP) is an independent network member of CLA Global. See CLAglobal.com/disclaimer.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Columbia Vantage House Corporation and its subsidiary's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Columbia Vantage House Corporation and its subsidiary's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information listed in the table of contents is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

King of Prussia, Pennsylvania
October 24, 2024

COLUMBIA VANTAGE HOUSE CORPORATION
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
JUNE 30, 2024 AND 2023

	2024	2023
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 3,067,253	$ 2,069,106
Current Portion of Assets Limited as to Use	909,960	888,485
Investments	10,984,380	11,546,792
Accounts Receivable	823,473	433,123
Allowance for Credit Losses	(120,007)	(55,463)
Entrance Fees Receivable	-	233,975
Prepaid Expenses and Other Current Assets	267,240	282,078
Total Current Assets	15,932,299	15,398,096
ASSETS LIMITED AS TO USE, LESS CURRENT PORTION	4,433,540	4,203,338
PROPERTY AND EQUIPMENT		
Land	4,738,600	4,738,600
Building and Improvements	83,512,404	81,627,736
Furniture and Equipment	3,882,808	3,578,399
Construction in Progress	277,064	160,532
Total	92,410,876	90,105,267
Less: Accumulated Depreciation	(57,759,694)	(54,347,798)
Total Property and Equipment	34,651,182	35,757,469
RIGHT-OF-USE ASSETS - OPERATING LEASES	11,406	13,253
CONTRACT ACQUISITION COSTS, NET	721,749	638,117
Total Assets	$ 55,750,176	$ 56,010,273
LIABILITIES AND NET ASSETS (DEFICIENCY)		
CURRENT LIABILITIES		
Current Portion of Long-Term Debt	$ 1,135,000	$ 1,080,000
Accounts Payable and Accrued Expenses	1,684,869	1,665,630
Current Portion of Lease Liabilities - Operating Leases	3,977	13,322
Entrance Fee Refunds in Process	283,051	1,380,266
Current Portion of Statutory Refunds	1,505,114	1,409,560
Total Current Liabilities	4,612,011	5,548,778
Long-Term Debt, Less Current Portion	41,393,010	42,518,338
Escrow Payable and Other	1,634,489	1,234,452
Long-Term Lease Liabilities - Operating Leases	7,082	-
Refundable Entrance Fee Liability	48,203,248	49,379,106
Deferred Revenue from Entrance Fees	13,603,832	11,386,026
Total Liabilities	109,453,672	110,066,700
NET ASSETS (DEFICIENCY)		
Net Assets Without Donor Restrictions	(54,220,492)	(54,555,455)
Net Assets With Donor Restrictions	516,996	499,028
Total Net Assets (Deficiency)	(53,703,496)	(54,056,427)
Total Liabilities and Net Assets (Deficiency)	$ 55,750,176	$ 56,010,273

See accompanying Notes to Consolidated Financial Statements.

COLUMBIA VANTAGE HOUSE CORPORATION
CONSOLIDATED STATEMENTS OF OPERATIONS
YEARS ENDED JUNE 30, 2024 AND 2023

	2024	2023
REVENUE		
Resident Care Services	$ 12,341,853	$ 11,448,620
Health Care Services	6,310,554	5,044,629
Earned Entrance Fees	1,938,342	1,615,043
Contributions	153,537	58,873
Net Assets Released from Donor Restrictions	57,196	11,678
Total Revenue	20,801,482	18,178,843
EXPENSES		
Resident Care:		
Health and Resident Services	5,398,374	4,639,597
Dining Services	3,231,740	3,006,103
Housekeeping and Laundry	985,151	880,087
Total Resident Care	9,615,265	8,525,787
Management and General:		
General and Administrative	3,584,958	3,089,126
Plant and Maintenance	1,787,027	1,755,993
Depreciation and Amortization	3,652,253	3,436,070
Interest	2,188,224	2,262,875
Insurance	378,341	328,457
Real Estate Taxes	311,314	306,634
Total Management and General	11,902,117	11,179,155
Total Expenses	21,517,382	19,704,942
EXCESS OF EXPENSES OVER REVENUE BEFORE OTHER NONOPERATING INCOME (LOSS)	(715,900)	(1,526,099)
NONOPERATING INCOME (LOSS)		
Investment Income, Net	381,407	243,062
Gain on Sale of Investments	205,746	86,645
Net Unrealized Gain on Equity Investments	730,230	666,704
Loss on Disposal of Fixed Assets	(201,973)	(252,396)
Total Nonoperating Income	1,115,410	744,015
DEFICIT (EXCESS) OF EXPENSES OVER REVENUE	399,510	(782,084)
NET UNREALIZED LOSS ON FIXED INCOME SECURITIES AND OTHER INVESTMENTS	(64,547)	(371,163)
CHANGE IN NET ASSETS (DEFICIENCY) WITHOUT DONOR RESTRICTIONS	$ 334,963	$ (1,153,247)

See accompanying Notes to Consolidated Financial Statements.

COLUMBIA VANTAGE HOUSE CORPORATION
CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS (DEFICIENCY)
YEARS ENDED JUNE 30, 2024 AND 2023

	Net Assets (Deficiency) Without Donor Restrictions	Net Assets With Donor Restrictions	Total Net Assets (Deficiency)
BALANCE - JUNE 30, 2022	$ (53,402,208)	$ 496,221	$ (52,905,987)
Excess of Expenses Over Revenue	(782,084)	-	(782,084)
Contributions	-	14,485	14,485
Net Assets Released from Restrictions	-	(11,678)	(11,678)
Net Unrealized Loss on Fixed Income Securities and Other Investments	(371,163)	-	(371,163)
Change in Net Assets (Deficiency)	(1,153,247)	2,807	(1,150,440)
BALANCE - JUNE 30, 2023	(54,555,455)	499,028	(54,056,427)
Excess of Revenue Over Expenses	399,510	-	399,510
Contributions	-	75,164	75,164
Net Assets Released from Restrictions	-	(57,196)	(57,196)
Net Unrealized Loss on Fixed Income Securities and Other Investments	(64,547)	-	(64,547)
Change in Net Assets (Deficiency)	334,963	17,968	352,931
BALANCE - JUNE 30, 2024	$ (54,220,492)	$ 516,996	$ (53,703,496)

See accompanying Notes to Consolidated Financial Statements.

COLUMBIA VANTAGE HOUSE CORPORATION
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2024 AND 2023

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets (Deficiency)	$ 352,931	$ (1,150,440)
Adjustments to Reconcile Change in Net Assets (Deficiency) to Net Cash Provided by Operating Activities:		
Depreciation	3,514,261	3,331,403
Amortization of Deferred Financing Costs	25,310	25,310
Amortization of Bond Premium	(15,638)	(15,636)
Amortization of Contract Acquisition Costs	137,992	104,667
Entrance Fees Received, Net of Refunds of $7,105,190 in 2024 and $4,381,115 in 2023	1,978,629	3,805,247
Amortization of Deferred Entrance Fees	(1,938,342)	(1,615,043)
Provision for Credit Loss Expense	64,545	41,130
Gain on Sale of Investments	(205,746)	(86,645)
Unrealized Gain on Investments	(665,683)	(295,541)
Loss on Disposal of Fixed Assets	201,973	252,396
(Increase) Decrease in Assets:		
Accounts Receivable	(390,351)	(102,159)
Entrance Fee Receivable	233,975	155,361
Contract Acquisition Costs	(221,624)	(151,085)
Prepaid Expenses and Other Assets	14,422	(699)
Increase (Decrease) in Liabilities:		
Escrow Payable and Other	400,037	141,013
Accounts Payable and Accrued Expenses	(100,239)	(45,206)
Net Cash Provided by Operating Activities	3,386,452	4,394,073
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of Property and Equipment	(2,490,469)	(3,038,969)
Decrease (Increase) in Investments	1,433,841	(2,755,129)
Net Cash Used by Investing Activities	(1,056,628)	(5,794,098)
CASH FLOWS FROM FINANCING ACTIVITIES		
Principal Payment of Bonds Payable	(1,080,000)	(1,030,000)
Net Cash Used by Financing Activities	(1,080,000)	(1,030,000)
NET INCREASE (DECREASE) IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH	1,249,824	(2,430,025)
Cash, Cash Equivalents, and Restricted Cash - Beginning of Year	7,160,929	9,590,954
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH - END OF YEAR	$ 8,410,753	$ 7,160,929
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash Paid for Interest	$ 2,211,767	$ 2,262,875
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITIES		
Noncash Acquisition of Property and Equipment in Accounts Payable	$ 119,478	$ 286,254

See accompanying Notes to Consolidated Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Columbia Vantage House Corporation (the Corporation) was incorporated as a nonprofit, nonstock corporation on August 18, 1986 under the general laws of the state of Maryland to establish, sponsor, operate, and maintain a long-term residential "life-care" or "continuing care" community for the aged located in Columbia, Maryland. Vantage House LLC was also formed as a single member tax-exempt limited liability corporation to own the land and improvements. All of the land and improvements are leased by the Corporation for $1 per year, for a term of 99 years. The Corporation began operations on October 15, 1990 (occupancy date). As of June 30, 2024, the community had the following units available for occupancy: 200 Independent Living Units (ILUs), 26 Assisted Living Units, 24 Assisted Living Memory Care Units, and 44 Skilled Nursing Units/Beds (the Facility).

On June 23, 2008, the Corporation's board of directors formed the Columbia Vantage House Foundation, Inc. (the Foundation) as a separate legal entity, to support the nonprofit mission of Vantage House. The Foundation was renamed Columbia Vantage Point Foundation on April 22, 2019. The Foundation is organized as a single member corporation and is governed by a separate board of directors.

Principles of Consolidation

The consolidated financial statements include the accounts of the Corporation, Vantage House LLC, and the Foundation (collectively referred to as the Corporation). All material inter-company accounts and transactions have been eliminated in consolidation.

Use of Estimates

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

Cash, Cash Equivalents, and Restricted Cash

The Corporation considers all highly liquid investments with no restrictions on withdrawals to be cash and cash equivalents. Deposits from prospective residents, waitlist deposits, and assets limited as to use are considered to be restricted in nature.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Cash, Cash Equivalents, and Restricted Cash (Continued)

The following table provides a reconciliation of cash, cash equivalents, and restricted cash reported within the consolidated statements of financial position that sum to the total of the same such amounts shown in the consolidated statements of cash flows at June 30:

	2024	2023
Cash and Cash Equivalents	$ 1,367,497	$ 572,190
Restricted Cash:		
Admission Deposits	201,970	420,713
Waitlist Deposits	1,497,786	1,076,203
Total Cash, Cash Equivalents, and Restricted Cash Other than Assets Limited as to Use	3,067,253	2,069,106
Assets Limited as to Use:		
Current Portion	909,960	888,485
Long-Term Portion	4,433,540	4,203,338
Total Assets Limited as to Use	5,343,500	5,091,823
Total Cash, Cash Equivalents, and Restricted Cash Shown in the Statement of Cash Flows	$ 8,410,753	$ 7,160,929

Investments

Investments are measured at fair value. Investment income or loss (including realized gains and losses on investments, unrealized gains and losses on equity securities, interest, and dividends) is included in excess of expenses over revenue unless the income or loss is restricted by donor or law. Unrealized gains and losses on fixed income securities and other investments are excluded from excess of expenses over revenue.

Accounts Receivable and Allowance for Credit Losses

Resident accounts receivable are reported net of an allowance for credit losses to represent the Corporation’s estimate of expected losses at the consolidated statement of financial position date. The adequacy of the Corporation's allowance for credit losses is reviewed on an ongoing basis, using historical payment trends, write-off experience, analyses of receivable portfolios by payor source and aging of receivables, a review of specific accounts, as well as expected future economic conditions and market trends, and adjustments are made to the allowance as necessary.

Residents are not required to provide collateral for services rendered. Payment for services is required within 30 days of receipt of invoice or claim submitted. Accounts more than 90 days past due are individually analyzed for collectability. When all collection efforts have been exhausted, the account is written off against the related allowance.

Management believes the composition of receivables at year-end is consistent with historical conditions as credit terms and practices and the customer base has not changed significantly. At June 30, 2024 and 2023, the allowance for estimate of expected credit losses was $120,007 and $55,463, respectively.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Accounts Receivable and Allowance for Credit Losses (Continued)

Changes in the allowance for credit losses for the years ended June 30, 2024 and 2023 were as follows:

	2024	2023
Allowance for Credit Losses		
Balance, Beginning of Year	$ 55,463	$ 14,333
Provision for Losses	64,545	41,130
Amounts Written Off	(1)	-
Balance, End of Year	$ 120,007	$ 55,463

The opening and closing balances in accounts receivable from residents were as follows:

	Accounts Receivable from Residents
Balance as of July 1, 2022	$ 316,631
Balance as of June 30, 2023	377,660
Balance as of June 30, 2024	703,466

Entrance Fee Receivables

Entrance fee receivables represent entrance fees that are deferred for up to four months after a resident occupies a unit. Additional extensions may be granted provided additional payments are received. The receivables are expected to be collected during the immediately subsequent fiscal year and are included in current assets. Management determined that no allowance is necessary on the Entrance Fee Receivables.

Assets Limited as to Use

Assets limited as to use consist of investments set aside for statutory and other reserve funds, amounts temporarily restricted by donors, and amounts held by trustees under bond indenture agreements. Changes in the fair value of assets limited as to use are recognized in the consolidated statements of operations as unrealized gain or loss, except for where amounts have been restricted by donor or by law in which case they are reflected in the consolidated statements of changes in net assets (deficiency).

Property and Equipment

Property and equipment are stated at cost. Depreciation is calculated on a straight-line basis over the estimated lives of the assets. Estimated lives are determined using American Hospital Association guidelines. Useful lives range from 5 to 40 years. The Corporation capitalizes all expenditures for property and equipment costing $1,000 or more and having useful lives greater than one year. Repairs and maintenance are expensed as incurred. Depreciation expense for the years ended June 30, 2024 and 2023 was $3,514,261 and $3,331,403, respectively.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment (Continued)

The Corporation records impairment losses on property and equipment when events and circumstances indicate that it is probable that the assets are impaired and the undiscounted cash flows estimated to be generated by those assets are less than the carrying amount of those assets. Based on management's estimation process, no impairment losses have been recorded for the years ended June 30, 2024 and 2023.

Contract Costs

The Corporation has elected to apply the practical expedient provided by FASB ASC 340-40-25-4, and expense as incurred the incremental customer contract acquisition costs for contracts in which the amortization period of the asset that the Corporation otherwise would have recognized is one year or less. However, incremental costs incurred to obtain customer contracts for which the amortization period of the asset that the Corporation otherwise would have recognized is longer than one year are capitalized and amortized over the life of the contract based on the pattern of revenue recognition from these contracts. The Corporation regularly considers whether the unamortized contract acquisition costs are impaired if they are not recoverable under the contract. During the years ended June 30, 2024 and 2023, there was no impairment of contract acquisition costs. During the years ended June 30, 2024 and 2023, the Corporation recognized amortization expense of $137,992 and $104,667, respectively. At June 30, 2024 and 2023, the unamortized customer contract acquisition costs were $721,749 and $638,117, respectively, and are presented in the accompanying consolidated statements of financial position.

Obligation to Provide Future Service

The Corporation periodically calculates the present value of the net cost of future service and use of facilities to be provided to current residents and compares that amount with the balance of deferred revenue from advance fees. If the present value of the net obligation to provide future service and use of facilities exceeds the deferred revenue from entrance fees, a liability is recorded with the corresponding charge to income. No such liability existed at June 30, 2024 and 2023.

Net Assets

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

Net Assets Without Donor Restrictions – Include net assets available for use in general operations and not subject to donor restrictions. At times, the governing board can designate, from net assets without donor restrictions, net assets for a board-designated endowment or other purposes. At June 30, 2024 and 2023, the governing board has not made this designation.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Net Assets (Continued)

Net Assets With Donor Restrictions – Include net assets subject to donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Donor-imposed restrictions are released when a restriction expires, that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource has been fulfilled, or both. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. At June 30, 2024 and 2023, net assets with donor restrictions included $516,996 and $499,028, respectively, which were temporary in nature.

Excess of Expenses Over Revenue

The consolidated statements of operations and changes in net assets (deficiency) include excess of expenses over revenue as the performance indicator. Changes in net assets without donor restrictions which are excluded from such amount, consistent with industry practice, include unrealized gains and losses on fixed income securities and other investments.

Income Taxes

The Corporation is a nonprofit corporation as described in Section 501(c)(3) of the Internal Revenue Code (IRC) and is exempt from federal income taxes pursuant to Section 501(a) of the IRC.

The Corporation follows the provisions of the income tax standard regarding the recognition and measurement of uncertain tax positions. The application of these provisions has no impact on the Corporation's consolidated financial statements. The Corporation is not aware of any activities that would jeopardize its tax-exempt status or of any activities that are subject to tax on unrelated business income or excise or other taxes.

The Corporation has implemented processes to ensure corporate compliance with the Internal Revenue Service intermediate sanctions provision. These processes include annual review by the executive committee of executive team compensation, and annual review by the board of directors of the performance and compensation of the Corporation's executive director. The board engages in annual corporate compliance education, has adopted and reviews at least annually a written corporate compliance program and code of conduct, and has a detailed conflict of interest policy.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

New Accounting Pronouncements — Accounting Standards Update 2016-13

In June 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*. The main objective of the ASU is to provide financial statement users with more decision-useful information about the expected credit losses on financial instruments and other commitments to extend credit held by a reporting entity at each reporting date. To achieve this objective, the amendments in the ASU replace the incurred loss impairment methodology in current GAAP with a methodology that reflects expected losses, referred to as the current expected credit loss (CECL) model, and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. The Corporation adopted this new guidance, as amended, utilizing the modified retrospective transition method. The adoption of this Standard did not have a material impact on the Corporation's consolidated financial statements but did change how the allowance for credit losses is determined.

Revenue

Revenue consists of resident care services, health care services, entrance fees, and other and is reported at the amount that reflects the consideration to which the Corporation expects to be entitled in exchange for providing such services. These amounts are due from residents, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. The Corporation bills the residents and third-party payors for services on a monthly basis. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Corporation. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred. The Corporation believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to residents in the facility receiving skilled nursing services or residents receiving other services in the facility. The Corporation measures the performance obligation from admission into the facility to the point when it is no longer required to provide services to that resident, which is generally at the time of the termination of the resident contract.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revenue (Continued)

The Corporation determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors. The Corporation determines its estimates of contractual adjustments based on contractual agreements, its policies, and historical experience. The Corporation determines its estimate of implicit price concessions based on its historical collection experience.

Monthly Service Fees

The Corporation charges residents a monthly service fee which varies according to the contract type and the size of the living space occupied. Second persons are charged a separate fee.

Health Care Services

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

Medicare

The licensed nursing facility participates in the Medicare program. This federal program is administered by the Centers for Medicare and Medicaid Services (CMS). The nursing facility is paid under the Medicare Prospective Payment System (PPS) for residents who are Medicare Part A eligible and meet the coverage guidelines for skilled nursing facility services. The PPS is a per diem price-based system. Annual cost reports are required to be submitted to the designated Medicare Administrative Contractor; however, they do not contain a cost settlement. CMS finalized the Patient Driven Payment Model (PDPM) to replace the existing Medicare reimbursement system effective October 1, 2019. Under PDPM, therapy minutes are removed as the primary basis for payment and instead uses the underlying complexity and clinical needs of a patient as a basis for reimbursement. In addition, PDPM introduces variable adjustment factors that change reimbursement rates during the resident's length of stay.

Nursing facilities licensed for participation in the Medicare program are subject to annual licensure renewal. If it is determined that a nursing facility is not in substantial compliance with the requirements of participation, CMS may impose sanctions and penalties during the period of noncompliance. Such a payment ban would have a negative impact on the revenues of the licensed nursing facility.

Other

Payment agreements with certain commercial insurance carriers, health maintenance corporations, and preferred provider corporations provide for payment using prospectively determined daily rates.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revenue (Continued)

Health Care Services (Continued)

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Corporation's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlement are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in an implicit price concession impacting transaction price, were not significant in 2024 or 2023.

Generally, residents who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Corporation estimates the transaction price for residents with deductibles and coinsurance based on historical experience and current market conditions.

The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent charges to the estimate of the transaction price are generally recorded as adjustments to health care services revenue in the period of the change.

The Corporation has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors: payors, service line, method of reimbursement, and timing of when revenue is recognized. All resident services revenue for the Corporation is provided at the single campus located in Columbia, Maryland. The method of reimbursement is prospective payments, and the timing of revenue recognition is health care services transferred over time.

The composition of resident care services, and health care service revenue by primary payor is as follows for the years ended June 30:

	2024	2023
Medicare	$ 506,496	$ 919,192
Private Pay and Other	18,145,911	15,574,057
Total Resident Services Revenue	$ 18,652,407	$ 16,493,249

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revenue (Continued)

Health Care Services (Continued)

The composition of resident care services, and health care service revenue based on its lines of business, method of reimbursement, and timing of revenue recognition for the years ended June 30 are as follows:

	2024	2023
Service Lines:		
Independent Living	$ 12,620,943	$ 11,799,180
Assisted Living	3,094,066	2,480,826
Skilled Care	2,937,398	2,213,243
Total	$ 18,652,407	$ 16,493,249
Method of Reimbursement:		
Fee for Service	$ 18,306,799	$ 16,318,038
Other	345,608	175,211
Total	$ 18,652,407	$ 16,493,249
Timing of Revenue and Recognition:		
Services Transferred Over Time	$ 18,306,799	$ 16,318,038
Services Transferred at Point of Sale	345,608	175,211
Total	$ 18,652,407	$ 16,493,249

Entrance Fees

As of June 30, 2024 and 2023, the Corporation has two types of Residence and Care Agreements: Type A and Type C. Each of these contract types has a 90% refundable, 85% refundable, 80% refundable, 50% refundable, or a 50-month declining balance option. After the first month of occupancy, if a resident withdraws from the facility for any cause (including death), the resident (depending on the option selected by the resident in the residence and care agreement) is entitled to a refund of (1) 90% of the refundable entrance fees paid, less expenses (2) 85% of the refundable entrance fees paid, less expenses (3) 80% of the refundable entrance fees paid, less expenses (4) 50% of the refundable entrance fees paid, less expenses or (5) an amount calculated based on a 50-month declining refund formula. Payment of any refund of the entrance fee is deferred until the Corporation has accepted and entered into a residence and care agreement with a new resident who has accepted and paid the entrance fee. The portion of the entrance fee that is refundable to the resident on the condition that a new entrance fee is received for the same unit is reported as refundable entrance fee liability. Nonrefundable entrance fees are considered to contain a material right associated with access to future services, which is the related performance obligation. The nonrefundable portion is reported as deferred revenue from entrance fees and amortized to income using actuarial tables based on the estimated life of the resident (time based).

Management has estimated the current portion of refundable entrance fees based on historical experience. The estimated amount of entrance fees that is expected to be refunded to current residents under the terms of the resident contracts is presented as a current liability in the accompanying consolidated financial statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revenue (Continued)

Entrance Fees (Continued)

As of June 30, 2024 and 2023, the allocation of the various contract types was as follows:

	2024	2023
90% Refundable	61 %	68 %
50 Month Declining Balance	23	22
50% Refundable	6	3
85% Refundable	8	7
80% Refundable	2	-
Total	100 %	100 %

Leases

The Corporation leases equipment. The Corporation determines if an arrangement is a lease at inception. Operating leases are included in operating lease right-of-use (ROU) assets, other current liabilities, and operating lease liabilities on the consolidated statements of financial position. Finance leases are included in property and equipment, other current liabilities, and other long-term liabilities on the consolidated statements of financial position.

Right-of-use (ROU) assets represent the Corporation's right to use an underlying asset for the lease term and lease liabilities represent the Corporation's obligation to make lease payments arising from the lease. ROU assets and liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. As most of leases do not provide an implicit rate, the Corporation uses its incremental borrowing rate based on the information available at commencement date in determining the present value of lease payments. The operating lease ROU asset includes any lease payments made and excludes lease incentives. The lease terms may include options to extend or terminate the lease when it is reasonably certain that the Corporation will exercise that option. Lease expense for lease payments is recognized on a straight-line basis over the lease term. The Corporation has elected to recognize payments for short-term leases with a lease term of 12 months or less as expense as incurred and these leases are not included in the lease liabilities or right of use assets on the consolidated statements of financial position. Management has evaluated the Corporation's leases and determined that there are no material leases to disclose.

Advertising Expenses

The cost of advertising is expensed when incurred and included within the general and administrative financial statement line item within the consolidated statements of operations and changes in net assets (deficit). Advertising expense was $290,430 and $310,234 for the years ended June 30, 2024 and 2023, respectively.

Subsequent Events

In preparing these consolidated financial statements, the Corporation has evaluated events and transactions for potential recognition or disclosure through October 24, 2024, the date the consolidated financial statements were issued.

NOTE 2 LIQUIDITY

As of June 30, 2024, the Corporation has a working capital of $11,320,288 and days cash on hand of 204 days. As of June 30, 2023, the Corporation had a working capital of $9,849,318 and days cash on hand of 287 days.

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the consolidated statement of financial position date, comprise the following:

	2024	2023
Financial Assets at Year-End:		
Cash and Cash Equivalents	$ 3,067,253	$ 2,069,106
Accounts Receivable, Net and Entrance Fees Receivable	703,466	611,635
Assets Limited to Use	909,960	888,485
Investments	10,984,380	11,546,792
Total Financial Assets	15,665,059	15,116,018
Less: Amounts Not Available to be Used Within One Year:		
Restricted Investments	(516,996)	(499,028)
Admission Deposits	(201,970)	(420,713)
Wait List Deposits	(1,497,786)	(1,076,203)
Total Financial Assets Not Available to be Used Within One Year	(2,216,752)	(1,995,944)
Total Financial Assets Available to Meet General Expenditures Within One Year	$ 13,448,307	$ 13,120,074

NOTE 3 INVESTMENTS AND ASSETS LIMITED AS TO USE

The Corporation records investments and assets limited as to use at fair value. The estimated fair values of investments are as follows as of June 30:

	2024	2023
Money Market and Mutual Funds	$ 2,284,152	$ 3,470,902
Common Equity Securities	1,771,442	1,347,280
U.S. Treasury Obligations and Government Agencies	5,302,223	4,117,530
Corporate Bonds	1,626,563	2,611,080
Total Investments	$ 10,984,380	$ 11,546,792

NOTE 3 INVESTMENTS AND ASSETS LIMITED AS TO USE (CONTINUED)

Assets limited as to use are comprised of cash and cash equivalents and designated for the following purposes at June 30:

	2024	2023
Funds Held by Bond Trustee:		
Debt Service Reserve Fund	$ 4,433,540	$ 4,203,338
Principal Fund	343,008	318,407
Interest Fund	566,952	570,078
Total Assets Limited as to Use	5,343,500	5,091,823
Current Portion	(909,960)	(888,485)
Assets Limited as to Use, Net of Current Portion	$ 4,433,540	$ 4,203,338

Investment income for the years ended June 30, 2024 and 2023 was $1,252,836 and $625,248, respectively.

NOTE 4 FAIR VALUE OF FINANCIAL INSTRUMENTS

Fair value measurement applies to reported balances that are required or permitted to be measured at fair value under an existing accounting standard. The Corporation emphasizes that fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability and establishes a fair value hierarchy. The fair value hierarchy consists of three levels of inputs that may be used to measure fair value as follows:

Level 1 – Inputs that utilize quoted prices (unadjusted) in active markets for identical assets or liabilities that the Corporation has the ability to access.

Level 2 – Inputs that include quoted prices for similar assets and liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument. Fair values for these instruments are estimated using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows.

Level 3 – Inputs that are unobservable inputs for the asset or liability, which are typically based on an entity's own assumptions, as there is little, if any, related market activity.

In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

NOTE 4 FAIR VALUE OF FINANCIAL INSTRUMENTS (CONTINUED)

The following tables present the Corporation's fair value hierarchy for those assets and liabilities measured at fair value on a recurring basis as of June 30.

	2024			
	Level 1	Level 2	Level 3	Total
Assets:				
Investments	$ 10,984,380	$ -	$ -	$ 10,984,380
Assets Limited as to Use	5,343,500	-	-	5,343,500

	2023			
	Level 1	Level 2	Level 3	Total
Assets:				
Investments	$ 11,546,792	$ -	$ -	$ 11,546,792
Assets Limited as to Use	5,091,823	-	-	5,091,823

NOTE 5 REFUNDABLE LIABILITY AND DEFERRED REVENUE FROM ENTRANCE FEES

Entrance fees received for the years ended June 30, 2024 and 2023 were $9,083,819 and $8,186,362, respectively. For the years ended June 30, 2024 and 2023, entrance fees refunded were $7,105,190 and $4,381,115, respectively. Total net entrance fees collected were $1,978,629 and $3,805,247 for the years ended June 30, 2024 and 2023, respectively. As of June 30, 2024 and 2023, $49,708,362 and $50,788,666, respectively, of deferred resident entry fees are contractually refundable based upon the terms of the Corporation's refund policies.

The opening and closing balances in the nonrefundable portion reported as deferred revenue from resident entrance fees were as follows:

	Deferred Revenue from Entrance Fees
Balance as of July 1, 2022	$ 10,835,192
Balance as of June 30, 2023	11,386,026
Balance as of June 30, 2024	13,603,832

NOTE 6 EMPLOYEE SAVINGS PLAN

Effective July 1, 1995, the Corporation established a defined contribution plan under IRC Section 403(b). Effective January 1, 1999, the Plan was amended to include an employer match component. Pursuant to the terms of the agreement, employees are required to make a contribution in order to benefit from the Plan. The Corporation's matching contribution limit is discretionary. Full-time employees will be required to work three months of service and Part-time employees will be required to work one year of service defined as less than 1,000 hours per year in order to become eligible for matching contributions. Each participant may elect a basic contribution of a percentage of annual compensation subject to certain limitations. Contributions made by the Corporation were $67,820 and $59,171 in 2024 and 2023, respectively.

NOTE 7 LONG-TERM DEBT

Long-term debt is as follows as of June 30:

Description	2024	2023
Howard County, Maryland Revenue Retirement Community Revenue Bonds Series, 2016 Bonds due on April 1, 2046	$ 25,155,000	$ 25,510,000
Howard County, Maryland Revenue Retirement Community Revenue Bonds Series, 2017 Bonds due on April 1, 2044	17,585,000	18,310,000
Total	42,740,000	43,820,000
Add: Unamortized Bond Premium, Net	324,999	340,637
Less: Unamortized Debt Issuance Costs, Net	(536,989)	(562,299)
Long-Term Debt	42,528,010	43,598,338
Less: Current Portion of Long-Term Debt	1,135,000	1,080,000
Long-Term Debt, Less Current Portion	$ 41,393,010	$ 42,518,338

On October 1, 2016, Howard County, Maryland (the Issuer) issued $27,580,000 of fixed rate retirement organization revenue bonds Series 2016 on behalf of the Corporation. The bonds were issued at a premium of $732,194. Interest on the Series 2016 Bonds is payable semi-annually on April 1 and October 1 of each year. The Series 2016 Bonds bear interest at an average rate of 5.00%. The Series 2016 Bonds are secured by first mortgage liens on all the buildings, improvements, and equipment owned by the Corporation, a security interest in the Corporation's gross revenue and the right to offset against the Corporation's trustee held funds.

The proceeds of the Series 2016 Bond Issuance were used to repay a portion of the Series 2007 Bonds, to finance the cost of capital improvements, to fund certain required reserves and to pay the costs of finance. The proceeds of the Series 2017 Bond Issuance were used to repay the remaining portion of the Series 2007 Bonds after the issuance of the 2016 Bonds, to fund a portion of a debt service reserve fund for, and pay costs of issuance of, the Series 2017 Bonds. The capital improvements include the renovation of the Facility's common areas and expansion of its assisted living services to offer a dedicated memory support floor.

NOTE 7 LONG-TERM DEBT (CONTINUED)

The scope of the project consisted of the following: conversion of the 10 enhanced living units on the fifth floor of the Facility into two new 12-unit memory support neighborhoods; renovation of the fifth floor common areas such as dining, living, office, and circulation; renovation of dining areas including formal, bistro/casual, roof area, and pub; capturing of underbuilding area for new administrative areas, a theater, a classroom, and new cardio and rehab spaces; renovation and expansion of wellness areas such as the cardio, rehab, spa, and salon spaces; renovation of the administrative areas, café market, reception area, marketing and circulation; expansion and renovation of auditorium; and renovation of arts and crafts space and some storage and circulation space. These capital improvements were completed by the close of the prior fiscal year ended June 30, 2019.

On April 1, 2017, Howard County, Maryland (the Issuer) issued $22,530,000 of fixed rate retirement organization revenue bonds Series 2017 on behalf of the Corporation. The bonds were issued at a premium of $610,798. Interest on the Series 2017 Bonds is payable semi-annually on April 1 and October 1 of each year. The Series 2017 Bonds bear interest at an average rate of 5.00%. The Series 2017 Bonds are secured by first mortgage liens on all the buildings, improvements, and equipment owned by the Corporation, a security interest in the Corporation's gross revenue and the right to offset against the Corporation's trustee held funds.

Under the terms of the Series 2016 and 2017 Bonds, the Corporation is required to meet a number of covenants, including provisions related to the debt service coverage ratio, day's cash on hand covenants, and other covenants. As of June 30, 2024, management is not aware of any noncompliance with these covenants.

The Corporation is required to maintain certain deposits with a trustee that are included within assets limited as to use in the accompanying consolidated statements of financial position.

Deferred financing costs related to outstanding bond issuances as of June 30 are as follows:

	2024	2023
Deferred Financing Costs	$ 731,457	$ 731,457
Less: Accumulated Amortization	(194,468)	(169,158)
Deferred Financing Costs	$ 536,989	$ 562,299

NOTE 7 LONG-TERM DEBT (CONTINUED)

The aggregate amount of future principal payments for all long-term debt is as follows:

Year Ending June 30,	Amount
2025	$ 1,135,000
2026	1,195,000
2027	1,250,000
2028	1,315,000
2029	1,380,000
2030 and Thereafter	36,465,000
Total	$ 42,740,000

NOTE 8 MARYLAND DEPARTMENT OF AGING RESERVE REQUIREMENTS

The Maryland Department of Aging requires continuing care retirement providers to maintain certain operating reserves that equal 15% of the facility's net operating expenses, as defined by the state, relating to continuing care contracts. The reserves must be kept in reasonably liquid form in the judgment of the provider. Per provider regulations established by the Maryland Department of Aging, beginning January 1, 2023, the operating reserve requirement increased from 15% to 25% of net operating expenses.

The reserves are computed as of the end of the fiscal year and facilities had up to 10 full fiscal years after October 1, 1996 to meet these requirements. The reserves must be set aside at a minimum rate of 10% per year up to a total of 100% as of the end of the tenth fiscal year. The Corporation's required reserves under Senate Bill 543 for the years ended June 30, 2024 and 2023, based upon operating expenses of the prior year, are as follows:

	2024	2023
Reserve Required per Senate Bill 543:		
Operating Expenses	$ 19,704,942	$ 18,614,229
Less: Depreciation Expense	3,436,070	3,565,988
Less: Interest Expense	2,262,875	2,202,536
Net Operating Expenses as Defined by Senate Bill 543	$ 14,005,997	$ 12,845,705
Required Reserve under Senate Bill 543 for the Years Ended June 30, 2024 and 2023 (100% of Total Operating Reserve)	$ 3,501,499	$ 3,211,426
Cash and Marketable Securities Available for Operating Reserve as Defined by Senate Bill 543	$ 14,051,633	$ 13,615,898

NOTE 9 FUNCTIONAL EXPENSES

The Corporation provides services and housing to its residents. Expenses related to these services are as follows for the years ended June 30:

	2024		
	Resident Services	General and Administrative	Total
Salaries and Related Expenses	$ 7,876,581	$ 1,512,281	$ 9,388,862
Marketing and Occupancy	461,051	-	461,051
Information Technology	-	378,332	378,332
Property and Other Taxes	323,532	2,042	325,574
Telephone and Cable TV	178,970	1,129	180,099
Insurance	375,968	2,373	378,341
Supplies	491,998	7,354	499,352
Maintenance and Repair	246,595	3,256	249,851
Utilities	664,780	4,195	668,975
Food	1,058,281	-	1,058,281
Contracted Services	1,347,616	153,750	1,501,366
Other	485,550	101,271	586,821
Interest	2,174,501	13,723	2,188,224
Depreciation and Amortization	3,629,349	22,904	3,652,253
Total Expenses	$ 19,314,772	$ 2,202,610	$ 21,517,382

	2023		
	Resident Services	General and Administrative	Total
Salaries and Related Expenses	$ 6,931,763	$ 1,485,738	$ 8,417,501
Marketing and Occupancy	430,698	-	430,698
Information Technology	-	275,793	275,793
Property and Other Taxes	318,791	2,012	320,803
Telephone and Cable TV	169,297	1,068	170,365
Insurance	326,396	2,060	328,456
Supplies	425,394	10,384	435,778
Maintenance and Repair	335,750	-	335,750
Utilities	629,922	3,975	633,897
Food	986,210	-	986,210
Contracted Services	1,145,741	108,851	1,254,592
Other	337,146	79,008	416,154
Interest	2,248,751	14,124	2,262,875
Depreciation and Amortization	3,414,455	21,615	3,436,070
Total Expenses	$ 17,700,314	$ 2,004,628	$ 19,704,942

Functional expenses were allocated between Resident Services and General and Administrative based on square footage for natural classes, property and other taxes, telephone and cable television, insurance, utilities, interest, and depreciation and amortization. All other expenses were based on actual.

NOTE 10 COMMITMENTS AND CONTINGENCIES

Litigation

The Corporation periodically finds itself a defendant in legal suits that have developed in the normal course of business. The Corporation maintains professional liability insurance on an occurrence basis with limits of coverage which management believes to be adequate. No accrued claims liability has been recorded at June 30, 2024 and 2023. Although it is impossible to determine the ultimate resolution of matters that remain unresolved at this time, the Corporation believes that the matters will be resolved without significant negative financial impact.

Management Agreement

The Corporation has a management agreement in place through July 1, 2026. During the years ended June 30, 2024 and 2023, the Corporation incurred management fees of $557,714 and $488,004, respectively, including performance incentive fees of $60,000 and $-0-, respectively.

COLUMBIA VANTAGE HOUSE CORPORATION
CONSOLIDATING STATEMENT OF FINANCIAL POSITION
JUNE 30, 2024
(SEE INDEPENDENT AUDITORS' REPORT)

	Columbia Vantage House Corporation	Columbia Vantage Point Foundation	Eliminations	Total
ASSETS				
CURRENT ASSETS				
Cash and Cash Equivalents	$ 2,814,150	$ 253,103	$ -	$ 3,067,253
Current Portion of Assets Limited as to Use	909,960	-	-	909,960
Investments	10,325,756	658,624	-	10,984,380
Accounts Receivable	823,473	-	-	823,473
Allowance for Credit Losses	(120,007)	-	-	(120,007)
Prepaid Expenses and Other Current Assets	274,309	-	(7,069)	267,240
Total Current Assets	15,027,641	911,727	(7,069)	15,932,299
ASSETS LIMITED AS TO USE, LESS CURRENT PORTION	4,433,540	-	-	4,433,540
PROPERTY AND EQUIPMENT				
Land	4,738,600	-	-	4,738,600
Building and Improvements	83,512,404	-	-	83,512,404
Furniture and Equipment	3,882,808	-	-	3,882,808
Construction in Progress	277,064	-	-	277,064
Total	92,410,876	-	-	92,410,876
Less: Accumulated Depreciation	(57,759,694)	-	-	(57,759,694)
Total Property and Equipment	34,651,182	-	-	34,651,182
RIGHT-OF-USE ASSETS - OPERATING LEASES	11,406	-	-	11,406
CONTRACT ACQUISITION COSTS, NET	721,749	-	-	721,749
Total Assets	$ 54,845,518	$ 911,727	$ (7,069)	$ 55,750,176
LIABILITIES AND NET ASSETS (DEFICIENCY)				
CURRENT LIABILITIES				
Current Portion of Long-Term Debt	$ 1,135,000	$ -	$ -	$ 1,135,000
Accounts Payable and Accrued Expenses	1,684,869	7,069	(7,069)	1,684,869
Current Portion of Lease Liabilities - Operating Leases	3,977	-	-	3,977
Entrance Fee Refunds in Process	283,051	-	-	283,051
Current Portion of Statutory Refunds	1,505,114	-	-	1,505,114
Total Current Liabilities	4,612,011	7,069	(7,069)	4,612,011
LONG-TERM DEBT, LESS CURRENT PORTION	41,393,010	-	-	41,393,010
Escrow Payable and Other	1,634,489	-	-	1,634,489
Long-Term Lease Liabilities - Operating Leases	7,082	-	-	7,082
Refundable Entrance Fee Liability	48,203,248	-	-	48,203,248
Deferred Revenue from Entrance Fees	13,603,832	-	-	13,603,832
Total Liabilities	109,453,672	7,069	(7,069)	109,453,672
NET ASSETS (DEFICIENCY)				
Net Assets (Deficiency) Without Donor Restrictions	(54,608,154)	387,662	-	(54,220,492)
Net Assets With Donor Restrictions	-	516,996	-	516,996
Total Net Assets (Deficiency)	(54,608,154)	904,658	-	(53,703,496)
Total Liabilities and Net Assets (Deficiency)	$ 54,845,518	$ 911,727	$ (7,069)	$ 55,750,176

COLUMBIA VANTAGE HOUSE CORPORATION
CONSOLIDATING STATEMENT OF OPERATIONS
YEAR ENDED JUNE 30, 2024
(SEE INDEPENDENT AUDITORS' REPORT)

	Columbia Vantage House Corporation	Columbia Vantage Point Foundation	Eliminations	Total
REVENUE				
Resident Care Services	$ 12,341,853	$ -	$ -	$ 12,341,853
Health Care Services	6,310,554	-	-	6,310,554
Earned Entrance Fees	1,938,342	-	-	1,938,342
Contributions	142,504	11,033	-	153,537
Net Assets Released from Donor Restrictions	-	57,196	-	57,196
Total Revenue	20,733,253	68,229	-	20,801,482
EXPENSES				
Resident Care:				
Health and Resident Services	5,398,374	-	-	5,398,374
Dining Services	3,231,740	-	-	3,231,740
Housekeeping and Laundry	985,151	-	-	985,151
Total Resident Care	9,615,265	-	-	9,615,265
Management and General:				
General and Administrative	3,488,687	96,271	-	3,584,958
Plant and Maintenance	1,787,027	-	-	1,787,027
Depreciation and Amortization	3,652,253	-	-	3,652,253
Interest	2,188,224	-	-	2,188,224
Insurance	378,341	-	-	378,341
Real Estate Taxes	311,314	-	-	311,314
Total Management and General	11,805,846	96,271	-	11,902,117
Total Expenses	21,421,111	96,271	-	21,517,382
(EXCESS) DEFICIT OF EXPENSES OVER REVENUE BEFORE OTHER INCOME (LOSS)	(687,858)	(28,042)	-	(715,900)
NONOPERATING INCOME (LOSS)				
Investment Income, Net	361,821	19,586	-	381,407
Gain (Loss) on Sale of Investments	218,633	(12,887)	-	205,746
Net Unrealized Gain on Equity Securities	650,670	79,560	-	730,230
Loss on Disposal of Fixed Assets	(201,973)	-	-	(201,973)
Total Nonoperating Income	1,029,151	86,259	-	1,115,410
DEFICIT OF EXPENSES OVER REVENUE	341,293	58,217	-	399,510
NET UNREALIZED LOSS ON FIXED INCOME SECURITIES AND OTHER INVESTMENTS	(59,152)	(5,395)	-	(64,547)
CHANGE IN NET ASSETS (DEFICIENCY) WITHOUT DONOR RESTRICTIONS	$ 282,141	$ 52,822	$ -	$ 334,963

CLA (CliftonLarsonAllen LLP) is a network member of CLA Global. See CLAglobal.com/disclaimer. Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC, an SEC-registered investment advisor.

EXHIBIT 18

Tye Ryan Murphy
Executive Director
AccentCare Hospice and Palliative Care
5457 Twin Knolls Rd, Ste 100
Columbia, Maryland 21045
tyemurphy@accentcare.com
410.533.8522

5/27/2025

To Whom It May Concern:

I am writing with strong support of Residents at Vantage Point, in their petition for additional skilled nursing beds through the Certificate of Need (CON) process.

As the Executive Director of AccentCare Hospice and Palliative Care, I have had the privilege of working closely with Vantage Point for several years. Our organizations have established a seamless partnership that embodies a true continuum of care—one that prioritizes the needs, values, and dignity of patients and their families.

This collaboration allows for timely and appropriate transitions from skilled nursing care to hospice services for residents whose goals of care align with comfort-focused support. The clinical teams at Vantage Point consistently demonstrate both excellence and compassion, ensuring residents receive comprehensive, person-centered care at every stage of their journey.

Importantly, Vantage Point also excels in supporting residents and families beyond their stay. Their team is committed to ensuring access to the full spectrum of home and community-based services, helping individuals transition safely and appropriately back into their communities when skilled care is no longer necessary.

Expanding Vantage Point's capacity with additional skilled nursing beds will not only address a clear and growing need in our region but will also strengthen the entire post-acute care landscape. This is a provider that integrates services responsibly, collaborates effectively, and always acts in the best interests of the people we jointly serve.

Thank you for your thoughtful consideration of this request. Should you need any further information or perspective from a hospice and end-of-life care provider, I am happy to provide it.

Sincerely,
Tye Ryan Murphy
Executive Director
AccentCare Hospice and Palliative cAre

CLARENCE K. LAM, M.D., M.P.H.
Legislative District 12
Anne Arundel and Howard Counties

Finance Committee

Chair
Executive Nominations Committee

Joint Audit and Evaluation Committee

Joint Committee on Ending Homelessness

Joint Committee on Fair Practices and State Personnel Oversight

Chair
Howard County Senate Delegation

Secretary
Asian-American & Pacific-Islander Caucus

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Miller Senate Office Building
11 Bladen Street, Room 420
Annapolis, Maryland 21401
410-841-3653
800-492-7122 *Ext.* 3653
Clarence.Lam@senate.state.md.us

May 20, 2025

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Subject: **Letter of Support for Open Certificate of Need Beds – Residences at Vantage Point**
To Whom It May Concern,

I am writing to express my strong support for the request submitted by Residences at Vantage Point, a 5-Star CMS-rated skilled nursing facility, to open additional Certificate of Need (CON) beds.

I have witnessed firsthand the exceptional quality of care and commitment to resident well-being consistently demonstrated by the Vantage Point community. The facility has long served as a trusted resource in our community, providing not only high-quality skilled nursing care but also acting as a hub for collaboration and education.

I am particularly encouraged by Vantage Point's ongoing commitment to providing access to its facility for all long-term care home and community-based services (HCBS) education and outreach efforts approved by the Maryland Department of Health, the Maryland Department of Aging, and the Maryland Department of Disabilities. Their willingness to open their doors to outreach programs ensures that residents and their families are informed about all available care options, including alternatives that support aging in place and greater independence.

The addition of CON beds at this facility would not only address growing demand but would also expand access to services for individuals who need them most.

I respectfully urge the Commission to approve this request, and I thank you for your continued leadership in ensuring quality and accessibility across Maryland's long-term care system.

Sincerely,

Senator Clarence Lam, MD, MPH
Maryland State Senate
District 12 | Anne Arundel & Howard Counties

Howard County ALF at Clarksville

ASSISTED LIVING

To Whom It May Concern,

I am writing on behalf of Howard County ALF at Clarksville to express our full support for the Residences at Vantage Point (RVP) in their application to reopen their Certificate of Need (CON) Skilled Nursing beds.

RVP has been a trusted and valued partner in the continuum of care within our community. Our collaboration has consistently been centered on shared values of quality, dignity, and person-centered care. We have had the opportunity to work alongside RVP in serving older adults in the region, and we continue to refer individuals to their services with confidence in their clinical capabilities and resident-first philosophy.

We believe that reopening the CON Skilled Nursing beds at RVP is not only beneficial but essential to meeting the increasing demand for post-acute and long-term care services in Howard County and surrounding areas. The addition of these beds will directly enhance the local healthcare infrastructure by ensuring that more residents have access to seamless transitions from hospital to rehabilitation to long-term care.

As a community partner, Howard County ALF at Clarksville is pleased to support this initiative. We are committed to continuing our collaboration with RVP by:

- Allowing RVP to promote our community as a long-term care option for their residents upon discharge from skilled nursing;
- Facilitating reciprocal referrals when clinically appropriate to ensure the highest standard of care for individuals transitioning between care settings;

Howard County ALF

5502 Harris Farm Ln, Clarksville, MD 21029.
Phone/Fax : (410) 670-CARE | Email : contact@HowardCountyALF.com
Web: www.HowardCountyALF.com

- Working closely with RVP's leadership to develop coordinated care strategies that align with our mutual mission.

We respectfully urge the regulatory authorities to approve RVP's CON application and support the reopening of their skilled nursing beds. Doing so will directly benefit our shared population and contribute meaningfully to the broader health and wellness of our region.

Please feel free to contact me directly should additional information be needed.

Sincerely,

Sridhar Raju Yavanamanda
Director
Howard County ALF at Clarksville
Email: Contact@HowardCountyALF.com
Phone: 410-670-2273 ext 1

Howard County ALF

EXHIBIT 19

RESIDENCES AT VANTAGE POINT
Connection • Community • Columbia

Virginia M. Thomas

President | Columbia, Maryland

Virginia M Thomas is currently the President of the Corporate Board at the Residences at Vantage Point and serves on the Foundation Board. She has been on the Corporate Board since 1996.

Since 2017, Ms. Thomas has been elected to the Columbia Association Board of Directors as the representative from Oakland Mills Village and currently serves as Vice Chair.

She is the CA Board liaison to the Climate Change and Sustainability Advisory Committee and the Board Operations Committee. She served on the CA Audit Committee and liaison to the Aquatics Committee. She was the Honorary Chair of the Winter Growth's 40th Anniversary Celebration in 2019. She serves on the Maryland Disabilities Forum and the Local Leadership Team for Oakland Mills Village project of the Howard County Local Children's Board.

Ms. Thomas retired as Director of Community Health for the Center for Health Program Development and Management (Hilltop Institute) University of Maryland Baltimore County. Ms. Thomas served 12 years as a State Legislator in the Maryland General Assembly and has been recognized as a legislative leader with expertise in healthcare environment, and human services. Prior to that she served for eight years on the Howard County Council and Zoning Board.

Known for her community outreach and volunteer activities, Ms. Thomas currently serves as Past President of the Maryland Gerontological Association where she served as President for 10 years. She is a past board member of the Mental Health Association of Maryland, Humanim, Grassroots, and numerous other Boards and Committees in Howard County and Maryland. She is also one of the Founders of the Rt. 1 Day Center Partners for the homeless, many of whom live in tents along Rt. 1. She also was one of the Founding Members of The Village in Howard and served on the board for two years. Ms. Thomas received an M.S.W. in Psychiatric Social Work from Rutgers University, an A.C.S.W. in Administration from Penn State, and a B.S. in Secondary Education/Psychology from Farleigh Dickenson University.

Bruce P. Martin

Vice President | Columbia, Maryland

A retired lawyer, Mr. Martin is a former Division Chief in the Maryland attorney general's office and counsel to the Department of Budget and Management, where he represented the state with regard to operating and capital budgets, fiscal matters, contracts and procurement, and employee relations. His experience also includes service as the Executive Director of the Montgomery County Merit System Protection Board; an assistant legislative officer to the Governor of Maryland; counsel to the state Departments of Juvenile Services, Disabilities, and Human Services; the Governor's Office of Minority Affairs; the Governor's Office of Crime Control and Prevention; and as an attorney in private practice. Mr. Martin is a graduate of the University of Maryland College Park and the University of Chicago Law School. Director since 2014.

Barbara Bednarzik

Treasurer | Columbia, Maryland

Retired director of social services, Winter Growth, Inc.; social worker with a focus on dementia care. Ms. Bednarzik has over 25 years of clinical and management experience in social work, mental health and aging. She was director of and assisting in developing several model assisted living programs, including Ruth Keeton House and Winter Growth. She served on various boards and advisory committees, including the Coalition of Geriatric Services, the Howard County Mental Health Committee, the University of Maryland School of Social Work Advisory Board, the Association of Community Services Board, and the Alzheimer's Respite Care Advisory Board. She holds an M.S.W. with a concentration in aging administration from the University of Maryland School of Social Work and Community Planning, and a bachelor's degree in elementary education from Waynesburg College.

Leo Bruette

Columbia, Maryland

Leo Bruette is a retired certified public accountant who worked in public accounting for more than 35 years. He is a retired tax partner of BDO USA, LLP, a CPA firm that operates internationally. Mr. Bruette managed tax engagements for a variety of business enterprises as well as non-profit entities and individuals. He received a B.A. – History from the University of Maryland, College Park; in addition, he holds a Certificate in Accounting and a M.S. – Taxation, both from the University of Baltimore. Mr. Bruette is a member of the Maryland Association of Certified Public Accountants and is a long serving member of its State Tax Committee.

Susan Castellan

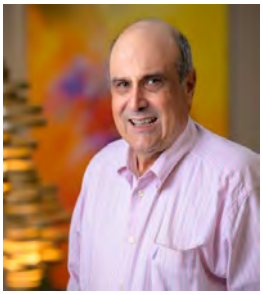
Secretary | Columbia, Maryland

Susan Catellan currently serves as vice president of The Whiting-Turner Contracting Company, one of the largest and most successful commercial construction companies in the United States. Over the years she has worked on numerous construction projects – both public and private, and both large and small — including Vantage Point more than 20 years ago. She received her B.S. in civil engineering from Villanova University, an M.S. in engineering technology and management from the University of Maryland, and a certificate in general theology from the Washington Theological Union.

Carol A. Romano

Columbia, Maryland

Dr. Carol A. Romano, Rear Admiral, U.S. Public Health Service (USPHS) (Ret.), is professor and dean of the Daniel K. Inouye Graduate School of Nursing at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. She received a diploma in nursing (1971) from the Geisinger Medical Center School of Nursing in Pennsylvania and earned her bachelor of science (1977), master of science (1985) and Ph.D. (1993) degrees in nursing from the University of Maryland School of Nursing. Dr. Romano is a fellow in the American Academy of Nursing and the American College of Medical Informatics. She has served in a variety of leadership positions in the USPHS in the Office of the Surgeon General, including chief nurse officer, and has also worked for 34 years at the National Institutes of Health (NIH), Clinical Research Center. She is contributor and editorial board member for several professional journals, recipient of multiple NIH, Department of Health and Human Services and university awards, and acknowledged in the World.Who"s.Who.in.American.Nursing.



Stephen Baron

Columbia, Maryland

Former Director of the District of Columbia Department of Mental Health which became the Department of Behavioral Health (2006 to 2015). During his tenure Steve led the development and management of the public mental and substance use disorder treatment services and supports which included ending the 37-year court oversight of the District’s mental health services as well as the Department of Justice Civil Rights of Institutionalized Persons Act (CRIPA) case against Saint Elizabeths Hospital.

Before joining District government, Mr. Baron was president of Baltimore Mental Health Systems, Inc. (BMHS), the mental health authority for Baltimore City for 17 years.

Prior to joining BMHS, Mr. Baron was employed by Sinai Hospital of Baltimore where working with the leadership of the Department of Psychiatry and a group of Baltimore businessman he helped create People Encouraging People, Inc. (PEP), a comprehensive community-based rehabilitation program for individuals with serious mental illness. Mr. Baron served as PEP’s first Executive director.

In 2016, he was selected by the National Association of Social Workers Foundation to receive its 2015 Ruth Knee-Milton Wittman Award for Lifetime Achievement in Health and Mental Health Practice.

A Baltimore native, Mr. Baron has served as an adjunct profession at the University of Maryland School of Social Work. He holds a Master of Social Work from Howard University and a Bachelor of Social Welfare from Adelphi University in Garden City, New York.

Victoria Imre

Ellicott City, Maryland

Victoria Imre is currently the President of Athenix Solutions, a technology company supporting the USG. During her career, Ms. Imre has worked with international and US based companies in the commercial and government sectors where she has served in operational, marketing, and program management leadership roles. She has been a resident of Howard County for over 25 years and has enjoyed volunteer positions in support of community organizations. She earned a B.S. in Communications from Towson University, Masters in International Management from University of Maryland, and is PMP Certified.

George Gallahorn, Ex Officio

Columbia, Maryland

A Vantage Point resident and President of the Vantage Point Residents' Association. George has been a resident of Columbia since 1972. His professional life as a physician was spent in the private practice of psychiatry and psychoanalysis. In addition, he was Clinical Associate Professor of Psychiatry at the University of Maryland School of Medicine, where he was a faculty member since 1972. Shortly after retiring, he and his wife moved to the Residences at Vantage Point in November 2019.

Andre Lingham

Columbia, Maryland

Andre Lingham is the Founder and President for the Center of Elder Justice and Education. It was established in 2021 and is a non-profit organization that promotes elder abuse awareness and education. Their mission is done by virtual and in person training to senior citizens, the public, government agencies, police departments and private institutions. Andre previously served over 30 years in law enforcement and retired from the Howard County Police Department in 2019 to focus full time on elder abuse awareness and education. While a member of the Howard County Police Department, he served as the Senior Citizen Liaison for 5 years. In 2014, Andre was named Howard Police Officer of the Year and 2015 American Legion Law Enforcement Officer of the Year for his work educating and protecting seniors.

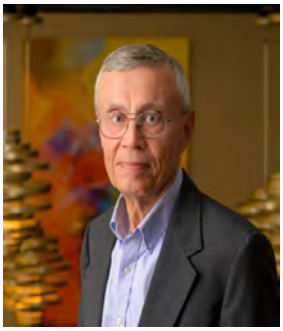
Frank L. Miles

Columbia, Maryland

Frank Miles is a retired Architect/Project Executive who worked 35 years in the Public Building Service of the General Services Administration (GSA). While at the GSA, he held the positions of Project Architect, Chief of the Architectural/ Structural Section and GSA Architect for the National Capital Region. In this position, Mr. Miles was responsible for the design and oversight of projects ranging from $500,000 to $5,000,000.

In addition to the above, while at the GSA, Mr. Miles also served as Development Director and Project Executive for major new construction projects with a construction value of over 400 million dollars. Upon his retirement from GSA, Mr. Miles was the principal owner Architect of FLM & Associates, providing design and consulting services for residential projects.

Mr. Miles received his Bachelor of Architecture Degree from Howard University and a EPM Fellowship Graduate Masters Certificate of Public Administration from University of Southern California. Mr. Miles is a member of the American Institute Of Architects.



John Wade

Elliot City, Maryland

John Wade is a retired actuary with 40 years of actuarial experience. He retired as Vice President & Chief Actuary from the National Rural Electric Cooperative Association, where he was responsible for actuarial services to a multi-billion dollar pension plan. He previously worked for the Employee Benefits Division of IRS and an actuarial consulting firm. He is a Fellow of the Society of Actuaries, and a Member of the American Academy of Actuaries. He received a B.S. in mathematics from Louisiana State University and a M.A. in mathematics from Duke University. He served as a member of the Joint Board for the Enrollment of Actuaries, including terms as both Chairman and Secretary.

Brendan Baloh

Ellicott City, Maryland

Brendan Baloh currently serves as a Division Vice President of The Whiting-Turner Contracting Company, one of the largest and most successful commercial construction companies in the United States. His senior housing involvement and experience in the Mid-Atlantic region has been vast over his career with Whiting-Turner and covers the continuum from independent living to long-term care. He served as project executive for the renovation at Vantage Point that was completed in 2018. Nationally he has supported Whiting-Turner's regional offices in many capacities in the senior housing industry and is Whiting-Turner's National Leader for Senior Living. Brendan started his career with Whiting-Turner in 2001 after graduating with a Bachelor of Architectural Engineering from The Pennsylvania State University. He received a Master of Business Administration from Loyola University Maryland in 2007.

Daniel Balkin

Maryland

Dan is currently unofficially retired, yet open to consulting, advisory, and board roles.

Over the course of his career Dan has been a member of the senior Management team at both a Community Bank (The Cape Cod Five Cents Savings Bank) and, locally in Maryland, at Tower Federal Credit Union. At both of these financial services companies Dan served key roles with respect to their Foundations. At Cape Cod Five he oversaw the day to day activities of the foundation which had a corpus of approximately $16 million and two full time staff members. He also was the chairperson of its Health and Elder Services Donation Advisory Committee and served on the foundation's board of directors. At Tower Federal he teamed up with the prior and current CEOs to launch the foundation and then to oversee its day to day operation including the development and vetting of grants, preparing board meeting packages and minutes, and all financial and other management functions. The two foundations respectively made grants of approximately $1 million and $500,000 annually.

Of course at both of the aforementioned companies, Dan's primary responsibilities pertained to the core business of banking. He oversaw Electronic Banking, ATM network, Customer Service, and Marketing functions. In his Senior Management Committee roles he sat on multiple oversight committees (Cybersecurity, Asset and Liabilities Management, Technology, Strategic Planning, Risk Management, etc.)

Master of Science in Management, 1987, Massachusetts Institute of Technology, Sloan School of Management, Cambridge, MA. Concentrations in Marketing and Corporate Strategy.

Bachelor of Arts, 1984, Dartmouth College,
Hanover, NH. Major in Art History.

EXHIBIT 20

AFFIRMATION

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

By: _____

Printed Name: Pierce Carey

Title: Executive Director

Date: May 29, 2025

AFFIRMATION

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

By: Kevin McDonald

Printed Name: Kevin McDonald

Title: Consultant

Date: May 31 2025

AFFIRMATION

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

By: Joseph Mooney

Printed Name: Joe Mooney

Title: Manager of Finance

Date: June 3 2025

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation		
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs		
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$0**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$0**	**$0**

N/A

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.