

MARYLAND HEALTH CARE COMMISSION

Certificate of Need Application Seasons Residential Treatment Program, LLC Upper Marlboro, MD Prince George's County



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6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

- | | | | |
|----|---|----|-------|
| a. | <u>Tyeaesis Johnson, Owner</u>
Name and Title | a. | _____ |
| b. | <u>1101 30th Street, NW, 4th Floor</u>
Street | b. | _____ |
| c. | <u>Washington, DC, 20007</u>
City Zip County | c. | _____ |
| d. | <u>202 295-1280</u>
Telephone No. | d. | _____ |
| e. | <u>202 452-8555</u>
Fax No. | e. | _____ |

7. Brief Project Description (for identification only; see also item #14):

Seasons Residential Treatment Program, LLC, a (proposed) 80-bed, Residential Treatment Center (RTC), is petitioning to operate as a licensed RTC and certified Psychiatric Residential Treatment Facility (PRTF) in the State of Maryland. Seasons Residential will meet all the clinical, safety and service standards set forth by the Center for Medicare and Medicaid (CMS) and the Department of Health and Mental Hygiene (DHMH).

The program aims to provide continuous (24 hours/7 days/365 days), intensive therapeutic services from licensed, clinical staff to support male and female residents between the age of 13 and 21 with a diagnosis of mental illness. The adolescents and young adults we serve will generally require treatment for more severe and chronic behavior disorders, emotional challenges and traumatic mental illness. These youth will need a more rigorous clinical program, are among the toughest to place in traditional residential programs, and have a high rate of recidivism.

Seasons Residential will support both hardware and staff secure units designed to treat the most refractory residents with a history of multiple "out of home" placements. Our model includes a diagnostic and assessment inpatient unit designed to help our stakeholders make informed decisions about next level of care placement.

The residential program will deliver short term, culturally competent, evidence-based treatment and clinical assessments to meet the immediate and long-term needs of our residents. Both components will work closely with community providers to extend and improve clinical outcomes and reintegration efforts.

Approximately 75% of the existing 35,000 sq feet of programming space will need some level of renovation to meet current licensing and occupancy use standards. The proposed renovations will also allow the program to meet the physical plant standards necessary to certify as a Psychiatric Residential Treatment Facility. The nature and intensity of services for a PRTF are outlined later in this application and are defined in **43 C.F.R. 483.352**.

If approved, the program will be located on 15-acre campus in Upper Marlboro, MD and Prince George's County and meets all local zoning requirements for the intended use.

8. Legal Structure of Licensee (check one from each column):

- a. Governmental Proprietary Nonprofit
- b. Sole Proprietorship Partnership **Corporation** Subchapter "S"
- c. To be Formed Existing

9. Project Services (check below, if applicable):

Service	Included in Project
ICF-MR	
ICF-C/D	
Home Health Agency	
Residential Treatment Center	
Ambulatory Surgery	
Other (Specify) Certified PRTF*	YES

*The proposed program will be licensed as a Residential Treatment Center (RTC), however, we are petitioning the Commission to differentiate the program and Need standard based on the *level and intensity* of services we wish to provide. The program is designed to support an intensive service model and will seek post-license certification for a Psychiatric Residential Treatment Facility (PRTF), as outlined in 42 C.F.R. 483.352 and described in greater detail in this application.

10. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	___/___		
ICF-C/D	Beds	___/___		
Residential Treatment	Beds	___/___		
Ambulatory Surgery	Operating Rooms			
	Procedure Rooms			
Home Health Agency	Counties	___/___		
Hospice Program	Counties	___/___		
Other (Specify) PRTF	Beds			80
TOTAL				80

11. Project Location and Site Control:

A. Site Size 15.1 acres

B. Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES NO (If NO, describe below the current status and timetable for receiving necessary approvals.)
See Attached: **Exhibit 1**

C. Site Control:

(1) Title held by: NVA Property, LLC

(2) Options to purchase held by: Seasons Residential Treatment Program, LLC

(i) Expiration Date of Option December 31, 2014.

(ii) Is Option Renewable? Y If yes, Please explain

A: Seasons Residential Treatment Program, LLC has the option to extend the purchase/closing period with NVA. Purchase of the property is contingent on receipt of approved Certificate of Need.

(iii) Cost of Option N/A

(3) Land Lease held by: N/A

(i) Expiration Date of Lease _____

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

(iii) Cost of Lease _____

(4) Option to lease held by: N/A

(i) Expiration date of Option _____

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

(iii) Cost of Option _____

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

(INSTRUCTION: IN COMPLETING ITEMS 12, 13 & 14, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

12. Project Implementation Target Dates (for construction or renovation projects):

A. Obligation of Capital Expenditure 0 months from approval date.

- B. Beginning Construction **0** months from capital obligation.
- C. Pre-Licensure/First Use **three (3)** months from capital obligation.
- D. Full Utilization **three (3)** months from first use.

13. Project Implementation Target Dates (for projects not involving construction or renovations): **N/A**

- A. Obligation of Capital Expenditure _____ months from approval date.
- B. Pre-Licensure/First Use _____ months from capital obligation.
- C. Full Utilization _____ months from first use.

14. Project Implementation Target Dates (for projects not involving capital expenditures): **N/A**

- A. Obligation of Capital Expenditure _____ months from approval date.
- B. Pre-Licensure/First Use _____ months from capital obligation.
- C. Full Utilization _____ months from first use.

15. Project Description:

Provide a summary description of the project's construction and renovation plan and all medical services to be establish, expanded, or otherwise affected if the project receives approval. Please attach this description as a separate sheet or section to your application. (Page 13-16)

Project Description

Seasons Residential Treatment Program will support the needs of male and female residents (programmed and housed separately) between the ages of 13 and 21 with severe, chronic and refractory behavior disorders. The youth in our proposed program are those with significant emotional and behavioral challenges, diagnosed mental illness, likely substance abuse and a pattern of academic truancy. Our target youth are among the toughest to place in traditional residential programs, have a high rate of recidivism, most likely failed in multiple community-based programs and were unsuccessful with in-home “wrap around” services.

If the proposed project is approved and licensed by the Maryland Department of Health and Mental Hygiene, Seasons Residential Treatment Program will seek Psychiatric Residential Treatment Facility (PRTF) certification based on federal standards mandated by the Center for Medicare and Medicaid Services (CMS).

The intensity of our clinical services will meet all federal regulations and standards for a PRTF, (definition: *42 C.F.R. 483.352*). Our residents and program will also meet the federal standards set in *42 C.F.R Part 441, Subpart D - Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Residential Facilities or Programs*. We will apply to the Maryland Department of Health and Mental Hygiene to operate the 80-bed facility under the RTC licensure **(see Exhibit 2)**.

Under the direction and supervision of our licensed and board-certified psychiatrists, the multi-disciplinary team will employ a holistic, evidenced-based, trauma-informed, approach to care. Our staff will draw on the most recent and relevant culturally competent, theoretical and applied treatment modalities and best-practice safety measures to support youth presenting with all forms of trauma, aggressive behaviors and with/out co-morbid substance abuse. Seasons Residential Treatment is designed for short-term, intensive placement, with a proposed average length of stay in our residential program of 4 to 6 months.

The proposed program is dynamic -- our team will be prepared to adjust individual treatment plans and tweak therapeutic resources to address more local issues of gang violence, gender identity and sex and human trafficking. The goal is to provide flexible, appropriate programming and interventions based on the specific needs of each resident.

The intensity of the program and the type of youth we wish to serve requires we make modifications to the physical plant to support positive staff interaction and round the clock clinical supervision. The proposed physical plant renovations will allow the team to embed nurses and therapists in each of the residential cottages, allowing the team to more quickly and safely support the therapeutic needs of our residents.

If we are certified as a PRTF, we will also be required to have a separate seclusion room for residents who have resisted all other forms of de-escalation techniques. The site plan includes space allocation for seclusion rooms as outlined in **C.F.R 482, subpart G, Conditions of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities**.

The proposed project includes a diagnostic and assessment unit, residential program and strategic partnerships with community-based providers to support effective reintegration efforts and seamless discharge plans. At every level of care, we will collaborate with youth, family and placing agency to support decisions in three key areas: academic, therapeutic and social.

Diagnostic and Assessment Unit: The 18-bed, diagnostic and assessment inpatient unit is designed to help our referral partners make informed decisions about next level of care placement options. The average length of stay on the unit will be less than 30 days and will boast a dedicated clinical and support staff to ensure we are providing comprehensive formal and informal multi-source assessments, treatment planning and next level of care documentation. Initially, this unit will only serve male residents, however, future plans include expanding this unit by eight (8) beds to meet the demands of female residents in need of this level of care.

The overall goal of the diagnostic and assessment unit is to identify needs and triggers in an effort to prevent the escalation of behaviors leading to residential placement. The youth on this unit may have been recently discharged from other residential programs, or, are currently in the natural home or community congregate care and need a “tune up” in order to prevent disruption from their group or family home. Our clinical team will work closely with referral sources to make sure the best resources are wrapped around the youth and family and recommendations are targeted, measured and appropriate.

Residential Program: The 54-bed residential program will deliver the requisite clinical and academic best practices and assessments to meet the immediate and long-term needs of our residents. The residential program is framed by the principles in Positive Youth Development (PYD).

Positive Youth Development is a nationally recognized model that embraces, engages and involves all community stakeholders in the personal development process of at-risk youth. We will integrate PYD in all aspects of our program and will promote a culture where youth are valued and included in developing solutions. Key components of the residential component also include: *required* family therapy, individual counseling, group therapy and substance abuse *treatment*.

We are also very proud of the fully integrated model we plan to build through our local community partnerships and plan to use Building D (Dining Hall) as a training site and meeting facility for our community-based providers and referral agencies. We plan to meet with the local county health department, parent and family advocacy groups and Core Service Agency (CSA’s) to ensure we are maximizing and leveraging local resources.

We will collaborate with community-based programs *before, during and after* youth discharge from Seasons Residential. Post-discharge, our treatment team will continue to work with community providers and placing agencies to provide extra support in the youth’s natural home or school setting to prevent relapse and recidivism (regardless of the location of the youth’s natural home.)

In addition to our comprehensive clinical services, Seasons Residential Treatment will provide individualized academic programming for all residents. Youth referred to our program will likely

have significant gaps in their academic record and come to us with individualized education plans and/or special education needs.

Our academic program will be housed in the administrative building (school programming is approximately 9,000 sq feet) and includes therapeutic day and residential curriculum(s). The academic program will meet all the requirements outlined by the State of Maryland Department of Education for a *Type 1, Special Education School*. The proposed renovations to the academic building will allow our educational team to serve the needs of **Level V non-public and Level VI** students on our campus in full compliance of **COMAR 13A.05.01** and **COMAR 13A.09.09** and **COMAR 13A.09.10**.

Renovation Budget and specific improvements:

The proposed renovation budget of \$2,093,098 (Two Million Ninety Three Thousand Ninety Eight Dollars) will also bring the property located at 13400 Edgemoade Road in Upper Marlboro, MD, up to building code and programming standards outlined in **COMAR 10.24.07G** and Health-General Article, **§19-308, Annotated Code of Maryland, 10.07.04.08** (Physical Plant) with specific consideration of the following:

- .08D: Bathrooms
- .11: Food Services
- .15: Accommodations

The proposed physical plant renovation also considers the PRTF certification requirements outlined in *42 C.F.R. 483.352*, specifically, the construction team included consideration of the following:

- Seclusion room to be monitored 24 hours per day and 7 days per week by a member of our clinical team and used as a "last resort;"
- Office space for clinical therapists on every residential unit/each cottage;
- Office/medication administration space for nursing staff;
- Nurses embedded in each residential cottage - 24 hours per day/ 7 days per week nursing coverage;
- Locked office in administrative building for on-site medical records/storage room

Prior Property Use

The property operated as a 60+ bed (licensed RTC and certified PRTF) until 2006. From 2007 to 2009, the property was used as a Montessori School; however, only 60% of the programming space was used for school programming. During the time the program was used as a Montessori School, several of the buildings failed inspection and were given conditional Certificate of Occupancy permits.

The project requires extensive renovations in the dining hall and (relatively) minor renovations in the residential cottages, administrative/office building and school building to meet local and state regulations and Certificate of Occupancy standards. Under our proposal, all of the buildings will exceed State of Maryland building code as required by DHMH licensing.

The property currently has more than 32,000 sq. feet of programming space including: four (4) separate residential cottages, separate school building, designated office/administrative space and dining hall (see the attached *Clarifications and Assumptions* under Project Drawings). The proposed renovation of this site will be of the existing footprint and will not include any new building construction.

Besides a staff trained to support youth who need a more rigorous clinical program to address both their behaviors and underlying mental health challenges, the youth we serve will require the safety and structure of a hardware secure campus with state of the art security and flexible programming space.

Seasons Residential will deliver therapeutic supports and programming with full consideration of the safety and security of our residents, staff and local community. The proposed renovations include a perimeter gate, hardware secure doors and an integrated security system.

The 15-acre campus is currently “open.” The fence currently in place covers approximately 30% of the perimeter and has been damaged by years of weather related wear. As part of the renovation plan, the fence will be demolished and replaced in order to properly integrate the security monitoring system and better ensure stakeholder safety. The fence was carefully selected to blend in with the surrounding community and support an environment that is serene and therapeutic.

16. Project Drawings: **(See Exhibit 3)**

Projects involving renovations or new construction should include architectural schematic drawings or plans outlining the current facility (if applicable), the new facility (if applicable) and the proposed new configuration for inpatient facilities. These drawings should include:

- 1) the number and location of nursing stations,
- 2) approximate room sizes,
- 3) number of beds to a room,
- 4) number and location of bath rooms,
- 5) any proposed space for future expansion, and
- 6) the "footprint" and location of the facility on the proposed or existing site.

*Each of the four (4) residential cottages will have an “embedded” nurses station. Each station includes a designated area for medication management and medication storage. The location of the nursing station will allow for more collaboration with all levels of staff and residents and provide more consistent documentation of any medication changes, adverse events, etc.

We are requesting licensing consideration for an 80-bed program; however, the attached drawings total 72 beds. Initial plans for the Diagnostic and Assessment Unit are for the unit to house male residents – the area of greatest need and demand.

We plan to grow the program very slowly and organically and do not plan to maximize census until the **end of Year 3** (post-license). For this reason, we would like the Committee to review the application and provide the program the option to grow the Diagnostic and Assessment Unit by 8 beds to accommodate female residents in **Year 4**, or, expand the residential beds by the same number based on the needs of the population (older youth, female residents, etc.).

The building square footage supports space allocation requirements outlined in **COMAR 10.07.04.08** (physical plant) for both (proposed) current and future usage.

For free-standing (including office-based) ambulatory surgical facilities, these drawings should include: **N/A**

- 1) dimensions of major architectural features and equipment of all operating rooms and procedure rooms, existing and proposed,
- 2) clear demarcation of restricted sterile corridor,
- 3) any proposed space for future expansion, and
- 4) the "footprint" and location of the facility on the proposed or existing site.

17. Features of Project Construction:

- A. Please Complete "**CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS**" describing the applicable characteristics of the project, if the project involves new construction. **(see below)**

CHART 1. Project Construction Characteristics and Costs			
*See Clarifications for Complete Scope of Work			
Campus Building	New Construction	Renovation	Cost
Building A: Administrative - 4,193 sq ft.	N	Y	\$167,425
Building B: Residential Cottages 1-4: Cottage A (3,116 sq ft., Cottage B (3,136 sq ft.), Cottage C (3,130 sq ft.), Cottage D(3,130 sq ft) Total sq ft.= 12,512 sq ft	N	Y	\$930,048
Building C: Administrative and School Building - 11,614	N	Y	\$76,813
Building D: Dining Hall - 2,832 sq ft	N	Y	\$368,350
Building Renovation Subtotal			\$1,542,636

Exterior Improvements and Landscaping (Allowance)	-	-	\$50,000
Entry gate (Allowance)	-	-	\$20,000
Security Fencing (Allowance)	-	-	\$60,000
Drain and Backfill existing pool (Allowance)	-	-	\$15,000
Exterior Improvement Subtotal			\$145,000
Design Fees			\$0
Permits/Review Fees			\$9,380
Contingency			\$92,000
Safety and Logistics			\$25,000
General Conditions			\$188,340
Fee			\$90,742
General Fees Subtotal			\$405,462
Total Budget			\$2,093,098

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

- B. Explain any plans for bed expansion subsequent to approval, which are incorporated in the project's construction plan. N/A
- C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

Availability of Utilities:

The project is a 15-acre site/campus that consists of seven (7) unoccupied buildings/existing structures. The campus has not been used in its full capacity in more than six (6) years. The dining hall has not been used in more than eight (8) years and will require the most extensive renovations to meet state and local licensing and safety standards (see plan/budget for more detail).

In order to estimate and project utility costs, we used data from the period when the campus was used as a residential treatment center (similar use) and adjusted for

current rates and costs. Our consumption data and expense forecast/estimates are based on the usage from the period when the RTC was fully staffed and operational in an effort to project an accurate picture of expected water, sewage and electricity usage.

As part of the purchase agreement, Seasons Residential Treatment Program, LLC, requested the current owner, NVA Properties, make substantial improvements to the property as a condition of purchase. The improvements and upgrades were completed in July of 2012 and will allow the program to quickly and seamlessly resume utility service at this location **(see Exhibit 4)**.

The completed upgrade to the water and sewer system will allow satisfactory water pressure and volume to our residents. All of the residential cottages will have separate 100-gallon water heaters, allowing sufficient hot water to our residents and staff.

The roofs on all of the campus buildings (except Building A and Building D, see site plan), are less than six (6) years old. Preliminary inspection of the new roofs suggests the improvements will allow the program to conserve and reduce energy consumption and reduce operational costs.

The physical plant upgrades and improvements completed by the current owner are under warranty and contribute favorably to our ability to meet state and local regulations, including health and safety requirements. All of the improvements made by NVA as a condition of purchase are outlined in detail in **Exhibit 4** and include:

Replaced (water) well, work completed in May of 2012 by Wooster Drilling Company, Waldorf, MD

Performed all services to ensure the sewage system is fully operational and up to code. Water Services, Inc., Waldorf, MD, completed work in July of 2012

Installed a direct read water meter tank at the water plant well house - work completed in July 2012 by Water Services, inc., Waldorf, MD

Replaced eight (8) HVAC units with new, energy efficient model(s), including new HVAC's in all residential cottages. Labor and materials performed by American Mechanical Services, Laurel, MD.

Utilities:

Water

Water Services, Inc., Waldorf, MD

Gas and Electricity

Palmco Power, LLC, or, MidAmerican Energy Company (both suppliers deliver services under Baltimore Gas and Electric, BG&E). Supplier selection will be based on best available commercial pricing/per therm rate.

Telephone

Verizon Business/Commercial Plan

We anticipate existing meters and services to be reactivated for our use through the local service providers and have an assumable contract with Water Services, Inc. The main service entrance for all utilities is Edgemeade Road off of Molly Berry Road.

Environmental

The site configuration does not have any jurisdictional wetland, floodplain, or stream location.

PART II - PROJECT BUDGET

INSTRUCTION: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a.	<u>New Construction</u>	\$	- 0 -
(1)	Building		<u>- 0 -</u>
(2)	Fixed Equipment (not included in construction)		<u>- 0 -</u>
(3)	Land Purchase		<u>- 0 -</u>
(4)	Site Preparation		<u>- 0 -</u>
(5)	Architect/Engineering Fees		<u>- 0 -</u>
(6)	Permits, (Building, Utilities, Etc)		<u>- 0 -</u>
	SUBTOTAL	\$	<u>- 0 -</u>
b.	<u>Renovations</u>	\$	1,755,976
(1)	Building		<u>1,755,976</u>
(2)	Fixed Equipment (not included in construction)		<u>200,000</u>
(3)	Architect/Engineering Fees		<u>90,792</u>
(4)	Permits, (Building, Utilities, Etc.)		<u>9,380</u>
	SUBTOTAL	\$	<u>2,056,098</u>
c.	<u>Other Capital Costs</u>		
(1)	Major Movable Equipment		<u>150,000</u>
(2)	Minor Movable Equipment		<u>50,000</u>
(3)	Contingencies		<u>92,000</u>
(4)	Other (Specify)		<u>145,000*</u>
	TOTAL CURRENT CAPITAL COSTS (a - c)	\$	<u>437,000</u>
d.	<u>Non Current Capital Cost</u>		
(1)	Interest (Gross)	\$	<u>- 0 -</u>
(2)	Inflation (state all assumptions, including time period and rate)	\$	<u>- 0 -</u>
	TOTAL PROPOSED CAPITAL COSTS (a - d)	\$	<u>2,493,098</u>

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	\$	- 0 -
b.	Bond Discount		- 0 -
c.	Legal Fees (CON Related)		<u>4,000</u>
d.	Legal Fees (Other)		<u>50,000</u>
e.	Printing		<u>3,000</u>
f.	Consultant Fees		- 0 -
	CON Application Assistance		- 0 -
	Other (Specify)		- 0 -
g.	Liquidation of Existing Debt		- 0 -
h.	Debt Service Reserve Fund		- 0 -
i.	Principal Amortization Reserve Fund		- 0 -
j.	Other (Specify)		- 0 -
	TOTAL (a - j)	\$	<u>57,000</u>

3. Working Capital Startup Costs \$ 1,143,662

TOTAL USES OF FUNDS (1 - 3) \$ 3,693,760

B. Sources of Funds for Project:

1.	Cash	\$	<u>3,693,760</u>
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net		- 0 -
3.	Gifts, bequests		- 0 -
4.	Interest income (gross)		- 0 -
5.	Authorized Bonds		- 0 -
6.	Mortgage		- 0 -
7.	Working capital loans		- 0 -
8.	Grants or Appropriation		
	(a) Federal		- 0 -
	(b) State		- 0 -
	(c) Local		- 0 -
9.	Other (Specify)		- 0 -
	TOTAL SOURCES OF FUNDS (1-9)	\$	<u>3,693,760</u>

Lease Costs:

a. Land	\$ _____	x _____	= \$ _____
b. Building	\$ 35,000	x 12	= \$ 420,000**
c. Major Movable Equipment	\$ _____	x _____	= \$ _____
d. Minor Movable Equipment	\$ _____	x _____	= \$ _____
e. Other (Specify)	\$ _____	x _____	= \$ _____

*Includes: Landscaping, fencing, security, etc.

**NVA has allowed Seasons Residential the option to lease the property for 12 months at a rate of \$35,000 per month and will also abate rent during the construction period. Seasons Residential can close at any time within the (approx.)16-moth lease period. All funds for the lease will be applied to the purchase price.

**PART III - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):
(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)**

COMAR Standard 10.24.07 G The State Health Plan.

List each standard from the applicable chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application. **(Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)**

COMAR Standard 10.24.07 G (1)(a-c): Core Principles

Programming need is outlined below, please note we were advised during the pre-application submission process to disregard the requirements outlined in COMAR Standard 10.24.07 G (1)(a)-(c) and COMAR Standard 10.24.07 G (2)(a)-(e). The Need standard is to be measured against the Core Principles outlined in COMAR Standard 10.24.07 G (1)(a)-(c).

COMAR Standard 10.24.07 G (3)(a): Need

The Need standard is to be measured against the Core Principles outlined in COMAR Standard 10.24.07 G (1)(a)-(c).

There is an urgent need in the local market for an organized *system of care* to support youth and families dealing with serious and challenging behaviors within the context of diagnosed mental illness. Seasons Residential Treatment Program is appealing to the Maryland Health Care Commission to view this project as a useful investment, which will benefit State of Maryland residents and targeted populations in the surrounding region.

According to local placing agencies, there is a significant gap in residential services for tough to treat, older youth who present with more refractory behaviors and traumatic mental illness. We believe this project is an opportunity to deliver a comprehensive, clinically solid program using the latest evidence-based research and practices to treat this "difficult" population.

Although the local needs of youth and families have changed greatly over the past 12 years, there has not been a petition to expand residential programming at this level of care in Maryland during this time. By virtue of the submission of this application and the research conducted therein, there is strong evidence from various stakeholders supporting the need for more clinical programming to treat distressed youth and families.

We are petitioning for project consideration based on our ability to serve the specific behavioral healthcare needs of an underserved, "tough to treat" population including older youth and youth with serious behaviors. Referral sources and placing agencies often find it difficult to place these youth in local residential

treatment programs and youth are often placed in programs far outside of their home community, making family involvement and reintegration challenging and lengths of stay longer than clinically necessary.

Our target population will benefit from our short term, intensive program designed to meet the highest level of non-acute inpatient treatment and standards. The success of our model is predicated on three key areas: our ability to connect “hard to reach” youth and families to sustainable local resources, our commitment to initiate and facilitate stakeholder collaboration, and our seamless communication across channels to improve clinical outcomes.

Seasons will also help satisfy the legislative mandate to keep Maryland youth and behavioral health resources in the State of Maryland. Citing data from the *2013 Maryland Department of Juvenile Services Residential and Community-Based Services Gap Analysis*, “29 boys have been sent to Mental Health Residential Placement’s located outside of Maryland over the past two fiscal years, and an additional 11 youth were sent to secure out-of-state programs that provide mental health or substance abuse treatment. These out-of-state placements suggest potential gaps in this type of residential care.”

According to the same report, submitted by the *Department of Juvenile Services in partnership with The Institute for Innovation and Implementation*, the authors noted the following:

“An assessment of boys’ needs indicates that Level III (and residential programming) should address the continuum of behavioral health with emphasis on alcohol and drug use, family functioning, aggression, and mental health. The report continues: “These findings are also supported by an analysis of boys who were placed in programs outside of Maryland in FY 12 and FY 13.”

In order to more closely explore the need for this level of programming, please note the following data from the report synthesized by The Governor’s Office for Children on behalf of the Children’s Cabinet. The report, entitled, “*FY 2013 State of Maryland Out of Home Placement and Family Preservation Resource Plan*” is distributed annually.

Utilization of Residential Treatment Centers in the State of Maryland

There are four placement categories for children in the State of Maryland:

- 1) Family Home Placement
- 2) Community-Based Placement
- 3) Non-Community-Based Placement
- 4) Hospitalization Placement

Residential treatment centers are a subcategory of *Non-Community-Based Placement* programs and represent more than one-third of the total costs of the funding category. The *FY 2013 State of Maryland Out of Home Placement and Family Preservation Resource Plan* indicates:

Cumulative data

- In 2013, *Non-Community-Based Residential Placement* costs were \$138M. The average bed per day rate for this category was \$338. **Figure 1 and 2.**
- **Figure 3** reflects a census snapshot taken on January 31, 2013. On this date, there were roughly **750** children funded by Maryland placing agencies placed in *Residential Treatment Centers*. While the number of youth in this level of care has decreased since 2009, Non-Community Based Placement(s) represents approximately 50% of the total number of youth funded in this category **Figure 4.**

Demographics:

- More than 66% of Maryland youth in out of home placement are between the ages of 12 and 21; 56% are male and 63% are African American. **Figure 5.**
- January 31, 2013, there were more than **155** Maryland youth in **Out of State** Non-Community Based Residential Placement **Figure 6.**
- The Department of Juvenile Services has the largest percentage of Maryland youth going to out of state (residential) programs. In the report summary, *The Governor's Office for Children* recommends the agency try to use more in-state facilities for court-involved youth who have diagnosed mental illness.
- More than two-thirds of Maryland youth in out of state residential programs are over the age of 12 and one-third were 18 and over **Figure 7** and approximately, 70% are African American males.

Increase in costs

- Costs to fund Out of State Placement in 2013 reflects a steady increase in the amount of funds leaving Maryland to support Community Based Residential Placements – **Figure 8** indicates approximately \$6.5M was spent in this category.

Data by Maryland placing agency:

Department of Human Resources (DHR) placed approximately 4% of their total population in Non-Community Based placements. The decision by DHR to place youth in these programs is largely driven by the behavioral needs of the child and/or involvement in the juvenile justice system and less so by the family's inability to provide a safe environment. Ranked in order, Baltimore City, Baltimore County and Prince George's County had highest number of youth in the custody of DHR.

According to the *Governor's* report, the growth in the number of older youth "has significant implications for placement needs and challenges." Although male and

female representation was evenly split, according to 2013 data from DHR, 67% were African-American and 28% were age 18 and over.

Figures 9 and 10 reflect DHR placement trends and total served for Non-Community-Based Residential Placement (these data includes RTC's, Correctional Institutions and Secure Detentions).

Department of Juvenile Services

The *FY 2013 Resource Plan* committee recommended the following for the DJS:

- Increase capacity for non-community based residential programs (including RTC's/PRTF's) for higher risk youth;
- Ensure non-secure programs can handle behaviors prior to placement, in order to reduce the number of youth being sent back to detention;
- Better leverage and utilization of the agency's new Central Review Committee and Multi-disciplinary Assessment Staffing Team (MAST), in order to move committed youth quickly to appropriate non-community-based residential placement levels with programming to support the needs of older youth;
- Keep lower risk youth at home supported by evidence-based programming;
- Streamline placement process for Out of State placements

Figure 11 Reflects a one-day placement snapshot; the data indicates approximately 66% of DJS Placements were placed in Non-Community-Based Residential Placement. African-Americans represented almost two-thirds of the total placements within the Non-Community Based Residential Placement category (**Figure 12**).

Figure 13 indicates 79% of DJS youth were between the ages of 12 and 17 and 21% were 18 and over. According to the DJS snapshot on January 31, 2013, 89% of Non-Community Based Residential Placements were males and 11% were females (**Figure 14**). Youth from Baltimore City (19.8%), Prince George's (16.9%) and Anne Arundel (12.8%) led the state in overall placements.

In 2013, DJS spent more than \$56M at a cost per day bed rate of \$281, in Non-Community-Based Residential Placement. The per diem is *relatively* low because of the large percentage of youth in this category who are placed in detention facilities, which tend to be more punitive and less therapeutic. (**Figure 15 and 16**).

According to the data in **Figure 17**, approximately 123 youth were placed in out of state programs on January 31, 2013 and approximately 22% were in residential treatment centers; 50% were placed in out of state substance abuse programs.

In **Figure 18**, the data indicates approximately 95% of out of state placements on this date were males; 80% are African American and 38% were 18 and over.

Mental Hygiene Administration

Residential Treatment Center(s) are the only placement subcategory funded by MHA (Figure 19 for trends data). Maryland Medicaid Assistance funds all Maryland youth placed by MHA.

Approximately \$66M was spent in FY 2013, (see cost data is reflected in Figure 20). Figure 21 reflects the bed costs per day paid by Medical Assistance.

The agency data reflects a categorical decrease in the number of placements over the last four years, as agencies moved to place youth in alternatives to PRTF's/RTC's. Total costs have been reduced by almost 50%; however, per bed day costs have stayed relatively flat. In FY '13, RTC per day costs were approximately \$313.

More than 80% of MHA placed youth are between the ages of 12 and 17 and approximately 7% are 18 and over. African-American males represent greater than 50% of the overall placement population in both gender and race categories. Baltimore City (23.2%), Baltimore County (21.9%) and Montgomery County (14.5%), have the greatest percentage of youth placed by MHA in RTC/PRTF level of care.

According to the one day census totals, MHA had approximately eight (8) youth in out of state RTC's. The agency has made a "focused effort to treat youth in state wherever possible and to fund only those youth who have special, or complex treatment needs."

Maryland State Department of Education

MSDE will fund youth who meet the level of care for a residential educational facility. These decisions are made at the local school system level in partnership with the parent and special education team. Less than .005% of the total population with disabilities will be placed in residential programs, according to the Governor's report, "the shift in services and types of programs utilized at the residential level is consistent with the shift in needs for the specific population groups.

It is also worth noting, according to MSDE, older students often stay in residential programs until they transition to adult services because their needs are often challenging and cannot be met in the community setting. On January 31, 2013, there were 0 youth placed by MSDE in residential treatment facilities.

Need in neighboring states:

While serving the needs of Maryland youth will be our first priority, we will also work closely with agencies in the District of Columbia, Virginia and West Virginia to bring youth closer to their families and community.

Initial agency discussions and research indicates the needs of youth and families in the District of Columbia are significant and meet our objectives of providing

excellent clinical care and keeping youth closer to their natural resources. Our proximity to the District of Columbia also makes Seasons Residential a great choice to treat tough to treat youth in the District of Columbia.

Unlike the State of Maryland, **all youth** who meet the level of care for RTC or PRTF placement are sent to out of state program. The District of Columbia **does not have any** licensed RTC's or PRTF beds, many youth are sent to RTC's as far away as Colorado and Utah, making it extremely difficult for parents and family members to participate in treatment team and next level of care planning. For families struggling to meet daily financial obligations, placing youth in programs in Virginia can also prove to be a significant barrier.

According to an article, published in 2009, *Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Centers*, "at any given time, the District of Columbia pays for approximately 300 to 550 children...to attend institutions called RTC's." Although this number seems high, it is pretty consistent with the total number of youth placed by the State of Maryland.

In a 2009 report filed with the City Administrator, "515 individuals under the age of 22 were in 96 different RTC's." The report also states, "approximately 35% of these youth were more than 300 miles from the District of Columbia." The authors noted that the District of Columbia has the second highest percentage of students in RTC's.

While the number of youth placed by District of Columbia agencies in RTC/PRTF's around the country has decreased in the past 5 years, there is still a significant number of youth placed in RTC programs far from the District of Columbia and the average length of stay for these youth is approximately 11 months.

The placing agencies are excited about the promise of Seasons Residential Treatment Program and our ability to more closely partner with key stakeholders and our ability to bring local resources to the youth and families. In initial meetings with placing agencies and referral sources, stakeholders are convinced there will be better collaboration and communication because of the proximity of the program and our ability to treat older youth with a history of trauma.

Last year, we responded to a solicitation to provide hardware and staff secure residential programming for youth in the District of Columbia to support the needs of youth in the custody of juvenile services in the District of Columbia. After visiting the project site and reviewing our proposal, Seasons Residential Treatment Program was **awarded a base, plus 4-year (5 year) contract with the District of Columbia and the Department of Youth and Rehabilitation Services.**

The contract was awarded for the diagnostic and assessment unit (**Exhibit 5**) and we are currently negotiating terms for the residential beds. While this is not a sole source contract, or promise of business by the District of Columbia, it indicates their support for our program and need for these beds. The contract is conditional on

licensed approval to operate as an RTC by the State of Maryland.

Currently, fewer than 15% of youth funded by District of Columbia agencies, are sent to current Maryland RTC/PRTF programs. Sources indicate there is a perception (that) Maryland RTC programs often “cannot handle DC youth.” There are only two programs in Maryland certified as a PRTF by the District of Columbia Department of Behavioral Health – the State Medicaid agency. During the last two RFP/solicitation cycles for PRTF level care (specifically targeting programs for tough to treat youth), no Maryland program applied for program consideration.

District of Colombia (primary) placing agencies:

Department of Youth and Rehabilitative Services (DYRS)

DYRS is responsible for the custody, supervision and care of young people charged with offense in either detained or committed capacity. According to a report on file with the Mayor’s Office in the District of Columbia, *Trends In DYRS Residential Treatment Center Usage*, residential treatment centers (RTCs) and psychiatric residential treatment facilities (PRTFs) play an important role in the continuum of services at the Department of Youth Rehabilitation Services (DYRS).

During FY2011, there were a total of 378 DYRS youth placed in RTCs/ PRTFs. Although this number has risen since FY2007, this upward trend primarily reflects the significant growth that has occurred in the overall DYRS committed population during that time.

In FY2007, the overall DYRS committed population was 541 youth; by FY2011, this number had increased to 1,269. This overall growth of the committed population helps explain the increase in the number of youth placed in RTCs and PRTFs (Figure 22)

In FY2011, DYRS spent \$15.4 million on RTC/PRTF placements. Although the agency’s expenditures on RTC/PRTF placements have increased since FY2007, there is reason to believe that these amounts will stabilize going forward due to a decrease in the total DYRS population and decline in rate of RTC/PRTF placement.

Although the agency is committed to decreasing the number and need for RTC/PRTF beds, the FY 2012 report indicates in January 2012, more than 200 youth funded by the agency remain in RTC, PRTF, sub-acute or diagnostic placement (Figure 23) and 187 youth were in out of state RTC placement (includes PRTF) (Figure 24).

DC: Department of Behavioral (Mental) Health

In the District, the Department of Mental Health (DMH), a cabinet-level agency operating separately from the Department of Health, provides financing and delivery of public mental health services. The Department of Behavioral (Mental) Health provides core services and community-based supports for mental health and substance abuse treatment for all District residents.

The Department of Behavioral Health, through direct agency placement and MCO's, funds approximately 150 youth in out of state residential programs. Approximately 70% of the youth placed and funded directly by DBH are youth in the custody of the Child and Family Services Agency (CFSA) and (custodial) wards of the District of Columbia. The Department of Behavioral Health manages CFSA placements in this level of care and per diem services are funded through Medicaid.

DC: Child and Family Services Agency

The DC Child and Family Services Agency (CFSA) is the public child welfare agency in the District of Columbia responsible for protecting child victims and those at risk of abuse and neglect and assisting their families.

Need for PRTF level program in Southern Maryland

There are only three (3) programs in the State that serve tough to treat youth over the age of 18 (see below) and also meet the rigorous certification standards for a Psychiatric Residential Treatment Facility (PRTF) designation.

None of the current programs are located in the area of the state where Seasons would be located. According to DJS data, "the Southern region has the fewest residential programs overall, with just four total." See below for a list of the current programs and the age(s) served:

Program Name	Youth Served	Certified PRTF
Adventist Behavioral Health (Rockville, MD & Cambridge, MD)	Adolescents, 12-18 years, Co-Ed	Not certified PRTF, admit only to age 18
Woodbourne Center	Adolescent Boys, 12-18 years	Not certified as PRTF; male only
Berkeley & Eleanor Mann Residential Treatment Center (Sheppard Pratt Health System)	Adolescents, 12-21 years, Co-Ed	Certified as PRTF; admit to age 21
Jefferson RTC (Sheppard Pratt Health System)	Adolescents, 12-21 years, Co-Ed	Certified as PRTF; admit to age 21, average length of stay, (according to website) is 11 months
Good Shepherd Services	Adolescents, 13-21 years (Co-Ed)	Certified as PRTF; admit to age 21; located in Baltimore County
Chesapeake Treatment Center	Males 13-21 years;	Sex offender program only
St. Vincent's Villa	Adolescents, 5-14 years (Co-Ed)	RTC; only to age 14 years old

COMAR Standard 10.24.07 G (3)(b) Sex Specific Programs

Seasons Residential Treatment will serve the needs of youth between the ages of 13-21 years who require focused, comprehensive clinical interventions. Youth admitted to our program will meet the level of care for intensive services and will generally have a history of trauma and multiple out of home placements. Our goal for both male and female residents is to therapeutically and behaviorally stabilize them and return them to their family and community as quickly as possible.

Our gender and age-specific programming is based on three core populations:

- 1) Youth ages 18-21 – with specific supports and programming for older youth (age 18-21);
- 2) Male residents who are at risk of regression. Our Diagnostic and Assessment Unit (males only) is designed to support referral sources who need assistance determining next level of care needs (i.e., community, group home, residential, etc.) and clinical appropriateness;
- 3) PRTF level residential beds for male and female youth who present with a history of trauma, refractory behaviors and multiple community placement, or other residential treatment center “failures.” These youth may also present with co-morbid substance abuse.

Each population will have a separate therapeutic, educational and physical environment consistent with their treatment needs and gender.

Seasons Residential Treatment will meet this standard in the following ways:

1. Male and female residents will be housed in separate housing cottages (Cottages A-D in project drawings);
2. All residents will receive group therapy in their housing units and individual therapy on the unit as appropriate;
3. All nursing staff will be embedded in each of the separate housing units and part of the therapeutic milieu. This allows a true multi-disciplinary clinical approach to care and immediate access should any clinical issues arise.
4. Diagnostic and Assessment Unit:
 - a. The diagnostic and assessment unit is a male-only unit. It is designed to deliver comprehensive assessments of each resident’s needs from an emotional, social, cognitive, academic, physical and behavioral perspective. It is a short-term (less than 30 days) program and will be staffed, programmed and operated to meet specific clinical objectives.
5. Academic programming and classrooms will be gender specific and each resident will receive individualized and customized educational and vocational tech instruction
6. All three (3) meals will be served in the dining hall according to unit and residential cottage, which guarantees the meal times will also be gender specific. The program is designed to serve no more than 20 residents per designated meal times.

COMAR Standard 10.24.07(3)(c) Special Clinical Needs

Seasons Residential Treatment will admit youth 13-21 years old with a full scale IQ of 70 and above. According to most clinical standards, 70 or below is considered a "low IQ" and qualifies as evidence that cognitive limitations existed prior to the age of 18, and limitations in two or more adaptive areas such as communication and self-help skills are present.

The youth we serve with scores closest to the admissions criteria of 70, will likely have some mild cognitive limitations, however, at this time, we will not serve youth with coexisting mental and developmental disabilities, disabilities that impairs multiple domains of functioning, or youth who are developmentally unable to function independently in his/her environment.

COMAR Standard 10.24.07(3)(d) Minimum Services

Seasons Residential Treatment will seek federal certification to provide services for youth who require the highest level of care outside of an acute setting. As such, we are committed to delivering a treatment program in a safe, structured setting with appropriate levels of staff and security protocols in place for the youth we serve.

Our program and service delivery model is based on a brief, goal-oriented approach. We believe this approach will help reduce lengths of stays and will maximize the time the youth spends in our care and away from their families.

All clinical and direct care staff will be fully integrated in to every level of the program and will have consistent and constant resident oversight. Our staff to resident ratio will be 1:6 which meets the current State of Maryland and federal standards, however, on first and second shift, the staff to resident ratio is higher and exceeds regulations and standards.

Youth will contribute to their treatment "action plan" and families will be required to participate in their care. Our team will work with the youth and family to move residents through the treatment program in a clinically appropriate manner and will consistently discuss next level of care plans before, during and after the admissions process.

We will partner closely with community-based resources including group home providers, independent living programs, appropriate educational programs and vocational/career training programs to develop long-term solutions for youth and families dealing with decades of trauma, behavioral challenges and mental illness.

We are committed to service excellence and will fully explore all of our community-based clinical partners and will establish MOU's to ensure residents have consistency in their care and treatment. Our goal is to identify resources early in the intake process and to have ongoing and engaging discussions about what tools the youth and family need to become contributing members of the community.

Our model is unprecedented in the level of care and support we will provide and is predicated

on the belief youth can succeed with programming which allows them to participate in their care.

Our program goals include:

- 1) Reconnecting youth to their community and families;
- 2) Supporting youth as they regain/earn public trust;
- 3) Helping youth identify and understand behaviors and triggers;
- 4) Engaging youth and families and encouraging them to fully participate in care;
- 5) Communicating disease state challenges and discussing how to manage issues during the program and post discharge;
- 6) Developing sustainable educational and vocational skills leading to direct employment and completion of high school diploma;
- 7) Providing excellent case management resources

COMAR 10.24.07 G(3)(d)

Follows are the minimum services we will provide to meet this standard:

Pre-Admission

Prior to admissions, our staff will work closely with external stakeholders, including prior placement(s) and providers, to determine if our program is the most appropriate and least restrictive setting for the resident. We will request the most recent and relevant academic, therapeutic and social history to inform a pre treatment plan and establish care goals *before* we accept the youth in our program.

Many programs do not commission a pre-treatment plan and rarely request a therapeutic interview prior to admission, Seasons Residential Treatment will make this a standard request to ensure we are the most appropriate placement and that the youth would not benefit from either a lower level of care, or a different treatment milieu.

Admission Process

Consistent with the standards set forth for PRTF certification, under **42 C. F.R. Sec. 441.152**, youth will have 24-hour access to a board-certified psychiatric and licensed, registered nurse upon admission, regardless of the time or day the youth is admitted to our program.

Seasons Residential Treatment will employ at minimum, two (2) board-certified child and adolescent psychiatrists. The assigned psychiatrist will manage the overall care and treatment of each resident and will conduct a comprehensive psychiatric evaluation as part of the admissions process.

All psychiatric evaluations, psychological assessments, social history, medical reports and educational reports (including psycho-educational, transcripts and IEP) will be reviewed by a multi-disciplinary care team under the direction and supervision of our board certified psychiatrist.

All referrals must meet the basic medical necessity criteria for Psychiatric Residential Treatment Services (PRTF) (see Exhibit 6). Consistent with PRTF level care, youth referred to

our program must be referred by a physician, or other licensed practitioner, and should meet least one of the following criteria:

- The child is at immediate risk of psychiatric hospitalization or has been removed from his/her home due to a mental or emotional problem; or
- Exhibits behavior which indicates a high risk of developing disturbances of a severe or persistent nature; or
- Is mentally ill or emotionally disturbed as reflected in a DSM-IV diagnosis and would benefit from specialized residential treatment services.

Upon approval of admission, the contact information for the clinical team will be shared with appropriate stakeholders, including the youth's family.

Seasons will set a new bar and standard for partnering with appropriate external stakeholder, immediately documenting and establishing community and campus resources and working towards an effective discharge plan. Although the plan will be based on preliminary treatment goals, we anticipate this early roadmap to be pretty thorough and extensive.

Our licensed therapists will lead daily client and agency interaction; however, both the psychiatrist and clinical director will have direct weekly input with the family, referral source and potential community resources during the first few weeks of care. The process is designed to establish early expectations and foster support for the multi-disciplinary team.

For residents admitted to either the residential or diagnostic/assessment unit, the treatment team will be identified and assigned within 72 hours of admission. As part of the admissions and intake process, the team will also review and assess prior placement information and documentation, family involvement, educational history, juvenile record (if applicable), presence/history of substance abuse, medical and psychiatric history and will also review risk factors related to care/treatment resistance. All residents will also be assessed, upon admission, for past and current trauma symptoms.

Treatment Planning

Individual treatment plans will be used to identify problem areas, establish goals and objectives, detail treatment options most likely to resolve or ameliorate problems, and establish timelines. The Seasons Residential Treatment team will use this document as a roadmap for improving a patient's status and guideline for team orientation, transcription and information.

Individual Group and Family Counseling

Every resident will have individual, group and family services as part of their treatment at Seasons Residential Treatment. All counseling is viewed within the context of the whole family. Family and community involvement is a cornerstone of our program. Research indicates, one family member experiencing problems can affect other members of the family. The team at Seasons Residential will involve the entire family from planning to treatment.

The issues addressed during the sessions are based on long and short-term goals and a comprehensive treatment plan developed in partnership with the resident, his/her family and the multi-disciplinary treatment team. Specific goals include: discharge planning, family and community reintegration, medication management, education and vocational training, life and independent living skills, and trauma history will be discussed.

General areas of therapeutic support include:

- Behavior and conduct disorder
- Sexual and gender identity
- Sexual and physical abuse
- Family dynamics
- Triggers for behaviors and trauma
- School avoidance/educational challenges
- ADHD, PTSD, Bipolar Disorder, Anxiety, Depression and Mood Disorders
- Understanding of disease state, mental health diagnosis
- Substance Abuse

Individual Therapy

Master's level therapist with experience working in a PRTF setting and with youth who have difficult behaviors and mental health challenges will provide individual therapy. Our individual counseling sessions will meet more often than those traditionally offered (3 times per week) and will allow for problem identification, root cause analysis and problem solving between the patient and his/her therapist.

Upon discharge, we will also work closely with the next level of care provider to coordinate care from our residential setting to the community-based provider. Our therapists will share notes, information and history, as appropriate, to ensure a seamless reintegration process, better therapeutic outcomes and decrease likelihood of recidivism.

Family Therapy

Family counseling at Seasons Residential Treatment involves the entire family. We will make every attempt to engage family members and will include relevant stakeholders the youth identifies as "family" to help with the treatment process. The goal is to help families work through and/or adjust to issues and challenges affecting the entire family. Family therapy may address specific issues surrounding parenting techniques, family dynamics, community/family reintegration concerns, stress management, foster care support, transitional needs and housing options.

The family therapy program emphasizes family relationships as an important factor in psychological health. We believe involving families in solutions is very beneficial in overall positive outcomes. The family therapy program is designed to help parent and child focus on positive qualities and reinforce the positive youth development model embedded in the residential program. The goal of this component is to give parents constructive behavior management skills and to guide them in developing techniques for how to hear, respect and respond to the youth's feelings.

Group Therapy

Residents are provided group therapy 2- 3 times per week. Group therapy involves a small group of residents (approximately 6-10). The residents meet with highly trained clinical staff to learn to cope with, or adjust to, a variety of challenges. The groups will take a variety of forms. Some focus on a specific topic or problem, while others address a number of different concerns. Under the direction of the group facilitators, the group is able to give support, offer alternatives, gently confront and promote healing.

Various modalities will be available including in our group therapy menu including traditional, process-oriented, experiential, and cognitive/behavioral. Core group curriculum includes, but is not limited to: trauma resolution and self-concept, social skills and communication, substance abuse, anger management and frustration tolerance and community reintegration.

Therapeutic/Treatment Modalities

Based on national best practices, clinical standards and proven positive outcomes, we believe the therapeutic modalities most appropriate for the type of youth we wish to serve must be: trauma focused, needs-based, individualized, dynamic, family and community focused, engaging and stepped in positive youth development.

Our general philosophy is consistent with the standards hypothesized by Marsha Lineham, Ph.D. Dr. Lineham, the original developer of the Dialectical Behavior Therapy model. According to Dr. Lineham, comprehensive psychotherapy must meet five critical functions. The therapy must:

- 1) Enhance and maintain the client's motivation to change;
- 2) Enhance the client's capabilities;
- 3) Ensure that the client's new capabilities are generalized to all relevant environments
- 4) Enhance the therapist's motivation to treat clients while also enhancing the therapist's capabilities;
- 5) Held in a structured environment so that treatment can take place

We have selected the following evidence-based practices as our principle tools and will incorporate similar tools based on the specific needs of the individual client. Our principal treatments will include: Trauma Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy (DBT) and a modification of Multi-Systemic Therapy (MST). All treatment modalities will be framed within the Positive Youth Development (PYD) model:

Trauma Focused Cognitive Behavioral Therapy: The cornerstone of our treatment philosophy. All therapists will be required to complete a minimum of 20 hours of web-based training during the first year of employment with Seasons Residential Treatment Program. Our clinical director will monitor and lead the successful completion of the program content from the *National Child Traumatic Stress Network* (see Exhibit 7)

The modules cover a host of experiential and expressive therapy techniques along with best

practices for psychiatric intervention, medication management and family therapy and counseling. This program was selected because of its robust research, treatment options/customization and outcomes data. The training program has multiple educational levels, explores the various nuances and specificities of trauma within various communities, cultures and environments, and appeals to a broad clinical education level.

Details about the *National Child Traumatic Stress Network*, including a complete list of treatment interventions, program/training modules and how Trauma –Informed Interventions area applied in different clinical and social settings, can also be found here: http://nctsn.org/nctsn_assets/pdfs/CCG_Book.pdf

Dialectical Behavior Therapy (DBT): Dialectical Behavior Therapy (DBT) The DBT group focuses on developing a clearer sense of self, learning healthy management of emotions, encouraging acceptance of the highs and lows of life without impulsive action, and creating, improving and maintaining healthy, stable relationships

DBT is a modification of cognitive behavioral therapy (CBT) and has been proven effective in residents with very refractory behaviors and youth who have encountered problems in the application of standard CBT. Clinicians have also found the model to be very effective with clients suffering from substance abuse and dually diagnosed adults and adolescents (see **Exhibit 8**)

Multisystemic Therapy (MST): According to the *Coalition for Evidence-Based Policy*, MST is a treatment primarily used for juvenile offenders. However, it has been used with great outcomes in all youth with refractory behaviors. The treatment uses a combination of empirical treatments (e.g. cognitive behavior therapy, behavioral parent training, functional family therapy) to address multiple variables (i.e. family, school, peer groups) that have been shown to be factors in juvenile behavior. It has proven to be an effective tool by all local juvenile services agencies in the District of Columbia, Maryland and Virginia.

Although MST is primarily used in community settings, the overall goal is to improve the youth's ability to make good decisions when choosing his/her peer group, and petitions the family to monitor his/her behavior(s). These goals are in direct alignment with our program goals, of early and on-going discharge planning, multi-disciplinary care approach and aggressive community and family reintegration strategy. In order to effectively monitor treatment outcomes, we will ensure the fidelity of this model is well defined and supported by our clinical team.

In the community-based model, masters-level therapists provide MST at the youth's home and community locations (e.g. school, recreation center), we will use the same process and tools in the residential setting and feel it will be easy to replicate based on our program intensity, targeted length of stay and required family/stakeholder involvement. Progression will be carefully monitored and therapist will work closely with the stakeholders to remove obstacles to goal achievement.

As part of family therapy, parents and engaged family members will receive MST to prepare them for the youth's discharge. We will work closely with the placing agency to start MST in the home for qualified youth and families. Upon discharge from Seasons Residential Treatment Program, the therapist will coordinate reports to local juvenile service agencies about the effectiveness of this tool and the responsiveness of the youth to the protocol.

Motivational Interviewing: This innovative approach to therapy developed by Stephen Rollnick, Ph.D., is widely accepted as a best practice approach in mental health as well as general healthcare practice when practitioners are challenged with encouraging clients to change an unhealthy lifestyle. Motivational Interviewing is based on a guiding therapeutic style which uses "listening more than questioning" to evoke from patients how change might be more compatible with the direction they want their lives to go in. This empathic listening technique can be useful in any consultation about change, and is supported by a growing body of research.

Personal Boundaries: The key to ensuring relationships is mutually respectful, supportive and caring is setting personal boundaries. Boundaries set the limits for acceptable behavior for each individual and for those around them. Therapists will work with residents in both the group and individual setting to address this issue.

Anger Management: Anger is a powerful energy that can be a destructive force or a channel for change. These groups discuss how to recognize personal triggers, gain control over angry expressions, develop resolution and communication skills, develop appropriate outlets, and redirect energy.

Substance Abuse Treatment: All youth will be evaluated for individual substance abuse treatment and counseling by our certified substance abuse therapist/counselor and will participate in group substance abuse education as part of the general program.

Our substance abuse counselor has experience completing complex bio-psychosocial assessments, delivering specialized treatment/discharge plans, monitoring client's behavior for relapse, and has participated in hundreds of treatment and family team meetings. Our general focus will be to provide therapeutic counseling and recommendations of treatment based on American Society of Addiction Medicine (ASAM) criteria. According to the ASAM website:

The ASAM criteria, also known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. The ASAM criteria are required in over 30 states and the District of Columbia.

The ASAM Criteria is an indispensable resource that addiction medicine professionals rely on to provide a nomenclature for describing the continuum of addiction services.

Assessments and Testing

Clinical staff will be required to use the most appropriate assessments and tools available to determine the problem severity and general course of treatment.

The general assessment protocol includes:

- 1) Review of placement agency recommendations (particularly with court-ordered youth)
- 2) General review of previous placement reports, in the absence of the most current data and information, we will administer: psychological and psychiatric evaluation and psycho-educational evaluations.
- 3) Conduct Mental Health and Substance Abuse Needs Assessments including: Child and Adolescent Service Intensity Instrument (CASII), the Massachusetts Youth Screening Instrument (MAYSI 1 and 2), The Trauma Checklist (TSC) and the Substance Abuse Screening Inventory (SASSI)
- 4) Determine Risk. For youth placed by juvenile services agencies, we will use the Structured Decision Making (SDM) tool to review factors and potential for re-offending and to determine the likely level of supervision the youth requires.

Youth admitted to our Diagnostic and Assessment Unit will likely be court-involved and referred by local juvenile service partners. For these youth, we will likely also use the following assessment tools **within 48 hours of admission**:

The Massachusetts Youth Screening Instrument - 2 (MAYSI-2): This instrument is a 15-minute self-report screening tool. It is easy to use and can be administered by staff with minimal training.

There are 5 subscales that have been validated for both males and females:

- 1) Alcohol/Drug Use
- 2) Anger-Irritability
- 3) Depression-Anxiety
- 4) Somatic Complaints
- 5) Suicide Ideation

Case Management/Planning

Our multi-disciplinary team, led by the resident's therapist, will work closely with the placing/referral agency and all stakeholders to coordinate case management, care planning and discharge/community reintegration plans. Through our daily interactions, our team will have substantial opportunities to get to know the needs of the youth and how to best support their program and aftercare treatment. We will have dedicated staff to support discharge planning and care coordination with the referral agency and family. The primary role of this department will be to:

- 1) Facilitate private stakeholder meetings on campus;

- 2) Provide videoconferencing hardware (at our expense) to support parent/family meetings and therapy;
- 3) Coordinate Individual Education Plans (IEPs), Individual Development Plans (IDPs) and Individual Treatment Plans (ITPs);
- 4) Support Youth and Family Team and Community Support Meetings

Recreational Therapy

Recreation Therapy will encourage patients to accept responsibility for their actions, set goals that challenge them to do their best, appropriately express feelings, improve stress tolerance, learn new approaches for problem solving, develop new leisure interests, and learn how to use leisure in positive and constructive ways.

Recreation therapy will utilize activity-based interventions to improve each child's physical, mental, emotional, and social functioning. Recreation therapy services will be offered daily to all populations and are facilitated by activity therapy staff.

Upon admission, each patient will be carefully assessed, and a recreation therapy plan will be developed to determine how to best meet identified needs through recreation therapy. Interventions are implemented to target specific needs and build upon existing strengths throughout their treatment course. Each resident's recreation therapy plan will be reviewed every 90 days and revised as needed to ensure patients are meeting targeted goals.

The Activity Therapy staff will carefully assess personal hygiene skills. The recreation therapy staff will ensure each patient is provided with all personal hygiene items, and ensure all personal needs are met.

Movement Therapy

The movement therapy program is designed to improve physical abilities, including muscle strength, balance, coordination, and flexibility, as well as provide opportunities to help build confidence and self-esteem by focusing on strengths and developing skills. Other benefits include helping patients gain greater self-reliance, which is essential to independent living skills, and increasing interpersonal skills by encouraging patients to join in activities that nurture social relations and create feelings of peer acceptance. Youth admitted to both our residential and diagnostic/assessment unit will benefit from this service.

Movement therapy will be held around our campus and is designed to take full advantage of our rural setting and acreage. We will use the basketball/soccer/volleyball court for general activities and hold Yoga and meditation classes in the movement studio (located in the school building). We plan to offer a range of structured physical activities to promote wellness and help youth remain active in support of a healthy lifestyle. Wherever possible, we will partner with local non-profit and community organizations to deliver bring these programs on campus.

Level System

Our team will implement a "level" system to observe and document youth behavior. The system will be supportive in its effort to show youth behavioral consequence. This system will be applied uniformly and fairly across the program and discussed during the admissions

process. This system will not be punitive, instead, it is positive and supportive, with specific discussions related to behavioral consequences.

All youth will be given a comprehensive overview of the level system and how it is used as a vehicle to promote day-to-day feedback and chart and document their success in various settings. The resident will be observed in all settings and feedback will be shared with the multi-disciplinary team and all external stakeholders as part of the assessment process.

Youth Advisory Board

Youth officers elected by their peers from each unit will serve on an agency board representing their milieu. This board, led by the Resident Advocate will meet monthly to review any safety or quality of care issues and make recommendations directly to senior leadership.

Food Services

Our dining hall is designed to accommodate up to 175 people (staff and residents) for three (3) full meals per day. The renovated site will also be used for "town hall" community meetings and general assembly. The dining facility will be available for agency inspection and review at all times. Once the program is operational, we will hire experienced staff to ensure we are in compliance with all OSHA, USDA and all other federal and state regulations and food handling requirements.

We will serve three (3) meals per day to residents and staff; daily snacks will be served to youth in the residential cottages. The meals will be aligned with the new nutrition science and standards and will meet federal food and nutrition standards. All food and health safety standards will be monitored by the director of food services and reported to the senior administrative team. The food services director will be responsible for coordinating special diets due to food allergies and religious beliefs.

Transportation

Trained transportation staff will provide secure transportation to/from court, home visits, wellness/medical appointments and admissions/discharge to higher/lower level of care. Our transportation team will also facilitate family and community reintegration planning. The team will transport parents, siblings and other supportive stakeholders to/from the facility to support treatment team meetings, parent/family therapy and other interactions that support positive outcomes and youth development.

Our transportation division is also designed to respond to the needs of our customers. We will transport youth to any next level of care placement via auto, train or air travel including safe and secure transport through airport security. We strongly believe the service will promote better hand off and drive communication between providers. The transportation service will be available on short notice to accommodate requests 24 hours per day/7 days per week.

Discharge Planning

Discharge planning is a critical part of each resident's treatment and our core values. Discharge plans will be prepared by the clinical staff and will include presenting problems at admission, a

summary of the course of treatment, progress toward each treatment goal, identification of remaining treatment issues, and recommendations for aftercare.

Generally, the patient will be recommended for successful discharge when he or she has demonstrated a significant decrease in the symptoms that led to admission and has demonstrated reasonable success in structured community reintegration activities.

Clinical staff will be made available to stakeholders during the transition process to provide on-site/phone consultation to help inform the patient's step-down placement. Clinical and direct care staff will also be available to accompany patients during initial home/community passes and to provide initial consultation following discharge.

Medication Management

Our clinical team will help residents and families understand the importance of medication compliance and management. Our goal is to help families understand:

- 1) Disease state – symptoms and triggers
- 2) Medication-related side effects
- 3) Substance abuse and prescription medication interaction
- 4) The importance of medication compliance

Transitional Services

Transitional services are offered to ensure each patient has appropriate skills and family support necessary for successful community reintegration. Because we plan to serve young adult residents, our discharge/transitional services will include housing support for youth eligible for independent living settings. We will work with local housing authorities to ensure appropriate adult level services are identified and made available as part of the discharge plan.

COMAR Standard 10.24.07G (3)(e) Treatment Planning and Family Involvement

Treatment Planning:

Seasons Residential Treatment is built on a system of care that is collaborative, accessible and comprehensive. Our multi-disciplinary treatment team will work closely with all internal and external stakeholders before, during and after admission and discharge, to ensure resources are: identified and maximized, treatment plans are measured and structured and results defined and delivered.

All of our academic, therapeutic and residential services and supports will be culturally competent and tailored to the unique values and needs of the youth, their families and the culture with which they identify.

All treatment plans will include therapeutic, academic and treatment goals and objectives that are measurable, meaningful and hold staff and youth accountable. The treatment plan is a road map designed to improve problem-solving abilities, increase communication skills, acquire daily coping abilities and enhance self-esteem.

The treatment plan will focus on returning youth back to their family and community and will be driven by the specific and individual needs of the youth and family. All interventions, benchmarks and services will be coordinated by the treatment team and will include input from relevant internal and external stakeholders.

Internally, the multi-disciplinary team will be led by a licensed, experienced, board-certified psychiatrist and will also include contribution and participation from various levels of professional and direct care staff. At minimum, our multi-disciplinary team will include the youth's unit specific registered nurse, teacher, milieu manager and master's level therapists.

Our treatment philosophy is based on keeping families together and returning healthy youth to their natural environment. Our treatment planning is built around effective family participation and engagement. We strongly believe involving client families in therapy can improve communications, reduce stress, and help with resident recovery.

We understand it may be difficult to consistently engage family members and many are juggling multiple priorities and challenges. Our multi-disciplinary team will focus on how to best encourage active and consistent family involvement by understanding barriers to family participation. We will focus on specific individual and family challenges, treatment goals and family history in order to design the best individual family care plan.

Our family treatment is strength and needs-based and focuses on the current family and youth assets. We will educate the family on the role of positive family functioning and how it relates to overall psychological health, stress management and successful youth/resident outcomes.

Our family treatment is positive, supportive and is prospective in its clinical approach. The treatment team will discuss the youth's current mental health and behavioral health challenges and history of substance abuse (as appropriate). We will also address ways to maximize the Seasons Residential program to ensure long term and sustainable treatment success. Our team will promote an atmosphere of hope in a low-stress, comfortable environment. Our family team meetings and therapy will be conducted in a home-like environment designated for family and youth interaction and therapeutic sessions.

Overall, our program model is designed to help parents and youth focus on positive qualities; give parents constructive behavior management skills; guide them in developing techniques for managing anger and teach parents how to hear, respect and respond to their children's feelings. Our treatment model focuses on rebuilding family and community trust, restoring family functioning and developing effective daily living/coping skills. Although we cannot make family therapy a mandatory part of our treatment plan, we will make every effort to engage family members in the treatment process at least once per month.

We will encourage family participation early and often and will require monthly participation in treatment team and/or family therapy. Our program is ideally located between Baltimore and Washington, DC and conveniently accessible from the Capital Beltway. Our location will allow our team to effectively serve a large percentage of families and engage other supportive stakeholders who may be a part of the youth's circle of support.

We plan to make campus access easy for all. Our transportation team will shuttle family members and other stakeholders from the Metro station to our campus. We have petitioned Prince George's County Economic Development to help offset the cost of running the "Metro shuttle." We have asked for these County funds to help the program facilitate parent participation and encourage and attract a diverse employee base.

For families who are unable to participate in person, we will provide HIPAA secure computer video service (hardware and software) available to facilitate family therapy in the home, agency or local outpatient setting. We are committed to this treatment component and will also provide financial assistance where money is a barrier to on campus therapy and visitation.

COMAR Standard 10.24.07 G (3)(f) Education

The primary purpose of educational programming at Seasons Residential Treatment is to help students develop the academic, vocational and technical skills needed to be successful. Our mission is to provide a positive educational experience, by building upon existing academic strengths and improving each student's investment and interest in education. The ultimate goal of the educational program is to prepare each student for "next level learning" and to provide a "dynamic roadmap" which reflects how to best achieve educational and career goals as a component of personal development.

All residents will be required to attend the nonpublic academic program as stated in requirements for licensed Residential Treatment Program and certified Psychiatric Residential Treatment Facilities. The nonpublic school program will meet the needs of Level V and Level VI general and special education students with serious behavioral challenges who need a more structured academic setting. Both our day and residential academic program will support general and special education youth with behavioral and emotional challenges

The non-public school program will be located on the Seasons Residential Treatment campus and will serve both day and residential students. We will support middle and high school-age youth and offer a range of traditional and non-traditional academic programming geared towards general education, special education and job readiness and will use the latest technology and experiential learning modules in concert with the required State of Maryland curriculum. The program will be suitable for students who have been unsuccessful in "traditional" educational settings and those that require highly structured and supportive instruction.

In accordance with the rules outlined in *COMAR 13A.09.10, Educational Programs in Nonpublic Schools and Child Care Treatment Facilities*, *COMAR 13A.05.01* and *COMAR 13A.09.09 Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities*, we are petitioning to serve youth in our PRTF facility as a **Type 1, General Special Education Program**. Due to the refractory nature of the youth we will serve and our goal for PRTF certification, we will also adhere to **COMAR 13A.08.04, Student Behavior Interventions**.

CERTIFICATION AND ACCREDITATION

Members of the academic team for Seasons Residential Treatment recently met with members of the *Maryland State Department of Education (DOE), Nonpublic Special Education Section and Division of Educator Effectiveness, Nonpublic School Approval Branch*, to discuss our statement of purpose and proposed non-public residential education program.

We will seek a Certificate of Approval (CofA), from the Maryland State Department of Education Nonpublic School division and follow the Maryland State Curriculum for all Maryland youth. Our school administrator(s) will partner with the certifying agency to make sure we are in compliance with **COMAR 13A.09.09.04** if the CofA is approved.

The academic staff will follow general curriculum standards to meet all local and state education authorities for the youth we plan to serve. The standards set forth in the Maryland State Curriculum are consistent with the core education/curriculum requirements for the region, including certification standards set forth by State Education Authorities (SEA's) in the District of Columbia, Virginia and West Virginia. Non-Maryland general and special education youth required by their home state SEA to take electives and credits outside of the Maryland State Curriculum will be handled on an individual basis through our education vendor, Connections Learning.

Within 12 months of approval from the Maryland State Department of Education, Seasons Residential Treatment will also seek accreditation from ***The Middle States Association of Colleges and Schools***. The Middle States Association of Colleges and Schools is defined as a voluntary, peer-based organization dedicated to educational excellence and improvement through peer evaluation and accreditation of public and private universities, colleges, secondary and elementary schools.

The Middle States Association of Colleges and Schools is one of the six regional accreditation organizations recognized by the United States Department of Education and the Council for Higher Education Accreditation. The website and more information about their accreditation standards can be found here: <http://www.middlestates.org/>

ASSESSMENT

During the admissions process, all youth will be assessed in areas related to the suspected disability, consistent with **34 CFR §300.304 (c)(4)** and **COMAR 13A.05.01**. Our education team, school administrator and clinical team will determine, document and report the best education plan based on a variety of assessment tools and available documentation from previous academic placement.

The team will also review the goals, education history and discharge plan of each student before a plan is developed. A variety of assessment tools will be used to determine how to best leverage the educational, vocational and career technology resources available at Seasons Residential Treatment and through local community partnerships.

STUDENT POPULATION **General Education Youth**

Nonpublic programs provide educational therapeutic and/or residential to students with disabilities. In the continuum of services for eligible students, federal and state laws allow programmatic options for students who may require exceptional educational and/or clinical interventions to meet their needs.

During the admissions process, the education team will determine the appropriate grade placement within the educational program and determine where/if the student has credit unit deficiencies. Students will receive an individual core curriculum plan based on their specific education needs within the guidelines of the standards set forth by their State Education Authority. Course content will be presented in an understandable manner designed to accommodate for various learning styles.

Special Education Youth

In accordance with Maryland State Curriculum and outlined in **COMAR 13A.09.10.17**, the academic program of Seasons Residential Treatment will provide an organized program of English, language arts, mathematics, science, social studies, and other curricular areas as appropriate for youth with special education needs. The academic program will help serve and promote the continuation and improvement of Individualized Education Program (IEP) services for day and residential students with disabilities.

In accordance with **COMAR 13A.09.10**, the academic team will maintain and implement policies and procedures for the admission of a student with special education needs into a general education program and will meet the higher standard for all levels within the program requirements, including: staffing, educational programming, teacher/student ratio, related services, assessments and administrative practices.

Young Adults

Older youth who have earned a high school diploma or GED, will program together as a separate school unit. These youth will receive pre-vocational and vocational instruction, along with life and independent skills development and support. Every effort will be made to coordinate "real world" experiential learning with an approved vendor or contractor as part of an apprentice/internship program.

We also plan to partner with Prince George's Community College, the University of the District of Columbia and Northern Virginia Community College, to offer online courses for eligible youth and will support them through the discharge process as part of our continuum of care.

Day School Students

All programs and services listed in this section will be available to non-residential day students attending the academic program on the campus of Seasons Residential Treatment. Typically, these youth will be referred to Seasons when the IEP team from the local public school has determined that the services the student needs can only be provided in a nonpublic setting. The public school district then pays the tuition for all special education and related services provided by the nonpublic school program. We will assume all responsibility for the implementation of the IEP

and collect/analyze all data on progress; however, the placing school district is ultimately responsible for making sure the students receive appropriate services.

Through FY 2018, we project a day school population of approximately 12 youth per school year and will limit the program to no more than 15 per academic year. This specialized program is designed to support youth with very refractory behaviors from local education authorities within 40 miles of the campus.

Youth may be referred and admitted to our program according to **COMAR 13A.05.01.16** in the following ways:

- Local School System Placement of a Student with a Disability;
- Parental Enrollment of a Student with a Disability in a Nonpublic School
- Unilateral Placement in a Nonpublic School by a Parent when FAPE is an issue;

ACADEMIC STAFF

The educational program at Seasons Residential Treatment will provide academic, behavioral and emotional supports in a comprehensive learning environment with the goal of helping each child achieve new skills and confidence in order to return to their home school district with the best chance of success.

Staff are trained and encouraged to employ the latest de-escalation techniques and strategies to manage student behaviors. Students are never expelled from educational (or any other) service, and we will only use exclusion, restraint or seclusion after every positive behavioral intervention has been completely exhausted *and* the student is at risk, or poses a serious risk to others.

In the instance where behavioral issues warrant temporary removal from the classroom, students will be provided individual instruction in the residential cottage or other designated areas until behaviors are determined appropriate.

Staff to Student ratio

Youth with special education needs will have a staff to student ratio of 1:7, based on the total special education census and outlined in **COMAR 13A.09.10.17**. Qualified teachers will be supported by a teacher's aide, and will also include a member of the direct care staff.

General education youth will have a staff to student ratio of 1:12. The minimum requirement is not outlined in the COMAR regulations and the requirement is excepted in **COMAR 12A.09.10.09 (2) (c)**.

Administrator

In compliance with **COMAR 13A.09.09.06**, and **COMAR 13A.09.10.18**, *Educational Program Personnel Requirements*, using the most restrictive requirement, we will employ an administrator/executive director with:

- A valid Maryland professional certificate as an elementary or secondary school supervisor or principal; or

- A valid Maryland professional teaching certificate in elementary or secondary education; **and**
- Valid Maryland professional certificate as a special education supervisor or special education principal; or
- Valid Maryland professional teaching certificate in special education

The administrator/school director will lead the day-to-day activities of the academic program, and manage all academic program staff. The administrator will also maintain current personnel files (including certifications and qualifications) for all full time and part time academic staff and will establish and adhere to a written policy stating the qualifications, duties, responsibilities and supervision of all academic staff.

The administrator will also have a separate and specific written policy and process for students admitted with IEP's. The academic team will be responsible for: securing, tracking, reporting, monitoring and complying with the IEP requirements for each youth. The team will partner with all external stakeholders to ensure all aspects of the IEP are consistently implemented and services delivered.

The administrator will determine, record and report the student calendar and schedule of the school day in accordance with the standards set forth in **COMAR 13A.09.10.14**. The administrator will also be responsible for unit of credit approval and will coordinate dissemination of transcripts to the local and state education authorities no later than 72 hours after student discharge. School records will be maintained by the education team and will be the primary responsibility and oversight by the school administrator.

Teachers/Instructors/Aides

All full time and part time teachers, including those providing instruction in GED and pre-GED preparation, will have, at minimum, a bachelor's degree from an accredited college or university. All teachers will be required to participate in family and treatment team meetings to help inform next level of care placement, education and therapeutic decisions.

All teacher aides will receive direct supervision and instruction from the teacher to whom the aide is assigned. The teacher aide will have earned an associates degree (preferred), will have at least one year of teaching/instruction, a high school diploma (required).

Career development and career technology staff will be required to have a minimum of 5 years of trade experience, a high school diploma and (preferably) experience working with students with behavioral challenges.

IEP Coordinator

In addition to working closely with the multi-disciplinary team during weekly treatment team meetings, the IEP coordinator will also be responsible for:

- Coordinating admission paperwork – determining the appropriate program and grade placement within the educational program;
- Partnering with the local school system to develop, adhere and amend IEP's,

- Participating in IEP meetings with local school system;
- Informing placement, education and therapeutic decisions within the lens of IEP requirement;
- Documenting related services and IEP compliance;
- Advocating for access to education rights under **COMAR 12A.05.01 (FAPE)**
- Disseminating discharge transcripts as part of our individualized educational assessment and education support process

CURRICULUM

Academic Calendar

Seasons Residential Treatment Program will offer a 12-month school year with four 12-week quarters, separated by one-week classroom breaks. The school year will be 228 days, which exceeds the minimum requirement of *at least 180 days of instruction (COMAR 13A.09.10.14 (b))*.

Summer School and Extended Year Services

We also plan to offer a summer program that will qualify the program for Extended School Year benefits as defined by the Maryland State Department of Education.

Students will attend summer school classes in the core subjects as outlined in the Maryland State Curriculum. However, our summer academic program focuses on credit retrieval and enrichment with a hands-on, recreation-based theme. Summer school elective courses include Poetry, Photography, Equine Science, Horticulture, Culinary, Creative Writing, Drawing and Painting, Woodworking, Computer Science, Model Building, Exploring Math and Science through Nature, and Photo Journalism.

Students will also be eligible to receive formal instruction in independent living skills, pre-vocational programming, pre-GED and GED preparation and career development/career technology education programming. All instruction will be delivered on the campus by trained and experienced staff of Seasons Residential Treatment, and/or contracted community partners.

Vocational Program and Workforce Development

The program is designed as an elective for older youth (18-21) who are still matriculating towards a high school diploma (or GED) and those youth in our residential program who have successfully completed their high school diploma or GED.

With the understanding not every youth has the goal of furthering their education upon graduation from high school, our goal is to develop an experiential program we can deliver on campus as part of the vocational training and workforce development program.

Students on this track will receive career and technical education in a classroom setting. Our instructors will focus on high growth sectors such as information technology and healthcare and we will infuse the schedule with opportunities for exposure to careers and work experience in these fields. We will also partner with local organizations to provide opportunities for youth to experience success working in more technical areas such as:

horticulture; recreation; graphic arts, culinary arts; carpentry; plumbing; electrical; and landscape maintenance.

Independent Living Skills/Transition Services

Seasons Residential will admit youth up to the age of 21. We will implement an independent living program that prepares young adults for community reintegration. We will provide them with the tools they need for movement into adult roles. The goal of the track is to engage them in their own "futures planning process," as well as providing developmentally appropriate services and supports.

The model involves youth (ages 18-21), their families, and other informal key players in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals. They will be encouraged to explore their interests and futures as related to each of the transition domains: employment and career, education, living situation, personal effectiveness/wellbeing, sober living and community-life functioning.

The classroom instruction will be delivered by an experienced teacher and reinforced through small group discussion led by a licensed therapist. The clinical aspect of the program will focus on personal development in the following areas:

- Interviewing and general communication skills
- Determining strengths
- Building confidence and trust
- Developing social skills
- Completing an application/resume
- Managing time
- Developing appropriate work habits and attitudes
- Creating a realistic budget, personal credit and how to open a bank account

Get Credit!

We created this program in partnership with Connections Learning (see below) to help youth obtain credits for courses they have previously taken and have been unsuccessful in completing. The partnership with Connectional Learning will allow youth who have had previous issues with truancy or multiple out of home placements, to potentially earn credits towards graduation.

We can also provide youth with the opportunity for credit by examination of up to another 6.5 educational units (depending on the home state LEA criteria). The credit retrieval program is a computer-guided instruction under the supervision of certified staff. The program is interactive and engaging and allows the youth to move at his/her own pace.

This is an excellent tool for youth in our diagnostic and assessment unit and youth who may need the extra support of our hands-on team, easy to use software and structured setting to "get credit" for a class they have been struggling with. This program can be implemented in a variety of ways and will be used in conjunction with full time school instruction.

Therapeutic Recreation

Our Therapeutic Recreation Program will provide opportunities for youth to express their creativity through music, yoga, dance and spoken word (poetry). The staff will encourage youth to develop healthy lifestyles during the program and will pair the physical activities with small group instruction regarding the benefit of movement as a coping mechanism and outlet.

Instructional Materials and Media Library

In addition to more than 8,000 square feet of classroom space in our school building, we have a state-of-the-art student computer lab outfitted with the latest computers and technology. All students will receive general computer skills training and have supervised use of the Internet for school research, job skill development, independent living preparation and general school coursework.

We have selected *Connections Learning*, an award-winning software and educational company, to complement the variety, quantity and quality of instructional materials we will provide to our students. The partnership with Connections Learning will greatly expand our school resources and ability to deliver quality education resources to youth with gaps in their educational record due to out of home placement or truancy.

The *Connections Learning* program was developed by educators with experience working with youth who need a more flexible and highly customized curriculum design. Each student will be given an educational assessment within 48 hours of admission and will begin some level of credit recovery and/or academic programming within 72 hours of admission.

The use of the *Connections Learning* program, in conjunction with our in classroom instruction, will allow the education team to offer immediate and comprehensive educational assessments and credit recovery to support our commitment to short-term placement and supporting youth in the least restrictive environment.

The ability to administer credit recovery programs in our diagnostic and assessment unit, will also be very helpful and will allow the multi-disciplinary team to more accurately determine next level of care educational placement.

The program curriculum, courses and certificates are aligned with the Maryland State Department of Education and local state education authorities including the District of Columbia and Virginia. Connections Learning also has an impressive list of local partnerships with Learning Disabled (LD) and Emotionally Disabled (ED), elementary and secondary school programs in the region.

Additional information about the company and related outcomes data can be found here: www.connectionslearning.com/connections-learning/home

DIPLOMA AND CERTIFICATE OF COMPLETION

The secondary school academic program at Seasons Residential Treatment will meet the academic, enrollment, credit and student service requirements outlined in **COMAR 13A.03.02**

for the issuance of a Maryland high school diploma or Maryland High School Certificate of Program Completion.

SCHOOL RECORDS

Seasons Residential will maintain permanent attendance records, grades, and transcripts for each student. Students are assigned individual grades by certified teachers and will receive credits based on recommended grades and coursework completed and in compliance with the student's (home) school district requirements.

COMAR Standard 10.24.07 G(3)(g) Medical Assistance

According to the demographic data from the *FY 2013 State of Maryland Out-Of-Home Placement and Family Preservation Resource Plan*, most of the youth we serve will meet the requirements to receive benefits under the Maryland Medicaid Assistance Program and will likely be enrolled in a local MCO provider prior to admission to our program.

Seasons Residential Treatment will adhere to the federal and state standards established in *The Maryland EPSDT Preventive Health Schedule*. The youth we serve will generally be at a higher risk of health problems compared to the same age group in the general population. Multiple out of home placements, placement in non-local residential programs and general family dysfunction, contribute to the data which suggests this group has a higher incident of preventative care non-compliance.

An integral part of the admissions process is to assess the physical, mental and developmental health of all youth referred to our program. For Maryland youth, this process will include determining when the resident is due for the required periodic screenings and whether the youth has ever participated in the screening program.

The clinical team will work closely with external stakeholders to gather all relevant medical records from local providers. Ideally, we will be able to access information from the youth's current primary care physician, partner with the provider to establish a wellness plan for local dental, auditory, vision and health visits and support a continuum of care that will extend to the community once the youth is discharged from our care.

We will check on the following federally mandated components of the *Maryland Healthy Kids Program*:

- Health and Developmental History
- Presence of a recent comprehensive physical examination
- Appropriate Laboratory Tests/Risk Assessments by Questionnaire
- Immunizations
- Health Education/Anticipatory Guidance

We will schedule additional age-appropriate screenings and follow-up visits, as medically necessary and in compliance with the requirements outlined in the *Maryland Healthy Kids Program*.

Seasons Residential Treatment will also contract with local Maryland Medicaid providers, including a pediatrician, primary care physician and nurse practitioners to conduct on site, emergency and on-call, wellness and physical exams, as part of our comprehensive around the clock medical services. In addition, PRTF certification requires and consistent with the needs of the population we will serve, our registered nursing staff will also be available 24 hours per day.

All patients will receive a comprehensive physical examination upon admission. In addition, patients will receive access to bi-annual dental screenings, vision, speech, and hearing screenings, and access to an on-site medical staff seven days a week for injuries or sick visits. We will also provide medical case management and transportation for routine medical needs.

Seasons Residential will contract with a local 24-hour urgent care center and is conveniently located within 5 miles of a full service medical/surgical hospital. All required immunizations are reviewed and updated upon admission, and during the influenza season, all patients are offered free flu vaccines.

Medications will be supplied by and delivered to our program by a “closed door” pharmacy. The pharmacy is contracted and set up to direct bill all local (MD, DC, VA) Medicaid agencies for all youth receiving Medicaid and third party health insurance benefits. The pharmacy will provide specialized clinical staff training and audit patient medication records.

COMAR Standard 10.24.07 G(3)(h) Staff Training

Seasons Residential Treatment Program is committed to recruiting, training and retaining the best staff at *all levels* of care. Our program leadership team will be unwavering in their expectation of excellence. In order for us to meet this goal, we must educate and empower staff and support their efforts to deliver exemplary care to a challenging population within a therapeutic framework.

We will embrace an employee culture of inclusiveness, open communication and collaboration at all levels within the organization. Starting with recruitment and “on-boarding” of new employees, our staff training will underscore our commitment to building and maintaining an organizational culture that is: respectful of diversity and difference, collaborative and cooperative, and supportive of all internal and external stakeholders. It is also critical to the success of the program that all staff feels supported and valued and is being coached to explore options with the organization beyond their current role.

The contributions of the direct care and direct service staff is critical to the success of the program. Operationally, the direct care staff (specifically, direct care technicians) will have the most frequent and consistent contact with our residents. In our service delivery model, we designed each cottage as a separate community within the campus. Our decision to embed nursing staff and therapist in the residential cottages, furthers the idea (that) we will work together as a team to understand and support the needs of our residents.

All levels of staff will be involved in youth care and program design/improvement. Staff will share information about the resident as directed in treatment team meeting, staff meetings and/or individually with the youth. The direct care staff will be fully integrated with the management team and all will serve to support and encourage youth success. The campus will meet in monthly town hall meetings and will have direct access to all levels of management

The attached *New Employee Orientation Schedule* (**Exhibit 9**) provides a general schedule of new employee orientation. The orientation is 80 hours in length and will be delivered during the first two weeks of employment. Staff will be paid for the orientation prior to assuming full job responsibilities. All levels of staff are required to attend the first week (40 hours) of general orientation. The second week of orientation is spent shadowing and indentifying a work mentor and learning the nuances of their specific job function for direct service staff.

Seasons Residential Treatment will require mandatory training for all new and returning full and part time, paid, unpaid and volunteer staff. The director of human resources will be responsible for maintaining staff training and employment records and ensuring employees and contractors adhere to written policies that detail program management, admissions, living and environment, case management, behavior management and program security.

Training and continuing education requirements and national accreditation standards will be outlined for all employees and will be maintained for stakeholder review and inspection, by the director of human resources. All employee certifications, training and continuing educational requirements will meet national standards and best practices and will also be managed by the human resources administrator.

Continuing Education

As part of our benefits package, Seasons Residential Treatment will support continuing education for all employees with at least 12 months of employment. All levels of professional and clinical staff will be able to take advantage of education reimbursement for approved continuing education courses. The courses must directly support their current role, are consistent with their professional development track and approved by their next level manager/supervisor. The tuition reimbursement benefit covers accredited on line, self-study and live classroom coursework and includes programs required for clinical and state licensure.

Direct service personnel will receive training in a variety of in class and online education. Many of these courses will lead to a certificate of completion or continuing education credit for professional staff. Below is an abbreviated list of courses we will make available to direct service staff in order to deliver best practice service to the youth and families we serve:

Intervention	Endorsed by	Required for	Comments
Trauma-Focused Cognitive Behavioral Therapy	SAMHSA's National Registry	All Therapists	Direct Care Staff will also be trained in the non-clinical aspects to recognize triggers, behaviors and non-confrontational strategies of de-escalation.
Dialectical Behavioral	SAMHSA's National	All Therapists	

Intervention	Endorsed by	Required for	Comments
Therapy (DBT)	Registry		
Multi-Systemic Therapy	SAMHSA;s National Registry	All Direct Service Staff	Proven "Evidence-Based Practice" shown to be effective in reducing recidivism for juvenile offenders. Easily implemented in the community and is inclusive of family and other stakeholders.
Motivational Interviewing	Best Practice and Evidence Based	All Direct Service Staff	Motivational interviewing is applicable to a wide range of behavior change/counseling settings and staff.
Positive Youth Development	Best Practice Model	All Staff	Endorsed
Good Lives Model of Offenders Rehabilitation	Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services	Therapist	For youth with very specific, very refractory behaviors and disorders
Human Trafficking Awareness Training	Department of Education; Department of Homeland Security	Therapist/Clinical Staff	General training designed to identify the signs of sexual exploitation
Handle With Care	Best Practice	All Direct Service Staff	National best practice standards for de-escalation of behaviors and crisis intervention

COMAR Standard 10.24.07 G (3)(i) Staffing

Seasons Residential Treatment Program will employ a competent staff of highly skilled full time and contracted, professional, paraprofessional and support personnel. Our staff will be proficient in the latest principles, goals, and advancement in behavioral health and treatment provision, including the principles of Positive Youth Development (PYD).

Seasons will have a staffing pattern that provides on-site trained staff for twenty-four (24) hour coverage, seven (7) days a week (including holidays) based on the number of youth placed in our care. The overall direct care staff to student ratio will be 1:6, with slightly higher staff to resident ratios during first shift hours.

We are committed to maintaining the highest physical, mental and psychosocial wellbeing of each resident. The level of supervision and oversight will have a direct impact on the safety, security and quality of care we will deliver and the outcomes we will share.

All professional staff will be required to submit updates, changes and challenges to all certifications or licenses required to perform, execute or legally deliver services to youth in our care. The Employee Handbook will clearly state what status changes must be reported immediately and what can/should be reported annually in order for the program to fulfill the proposed treatment goals and remain in good standing with our referral partners, funding sources, etc.

The proposed program will take the following steps to ensure we attract and retain a sufficient number of qualified professionals to meet the needs of the youth we wish to serve:

- Promote from within – establish a succession planning program consistent with program ideals and culture;
- Encourage use of tuition reimbursement, clinical certifications and continuing education benefit;
- Establish career tracks and professional development paths across functional areas and staff levels;
- Recruit staff through local social service agency relationships and workforce development initiatives including those targeting Veterans and other underserved groups;
- Partner with local universities to attend career fairs, conferences and on-campus events to recruit graduate-level clinicians and alum. Targeted universities include attracting students from the University of Maryland, George Washington, Howard University and Georgetown University;
- Provide training programs and internship opportunities to graduate-level students; allow them to shadow/support experienced staff;
- Create various staffing options for our highest turnover (staffing) category: direct care staff. Options will include: per diem, short-term and temporary shifts;
- Relocation assistance for qualified senior-level clinical and administrative positions;

COMAR Standard 10.24.07 G(3)(j) State Regulations

By virtue of this application, Seasons Residential Treatment Program intends to apply to all mandated federal, state and local health and safety regulations and applicable licensure and certification standards.

COMAR Standard 10.24.07 G(3)(k) Accreditation and Certification

Upon approval of the Certificate of Need from the Maryland Health Care Commission, Seasons Residential Treatment Program will immediately petition the State of Maryland Department of Health and Mental Hygiene (DHMH) for a license to operate as a Residential Treatment Center (RTC) in accordance with **COMAR 10.07.04**. The program will be jointly licensed as a Specialty Hospital-Psychiatric Facility as outlined in **COMAR 10.07.01**.

We intend to comply with all federal, state and local requirements to operate as a certified Psychiatric Residential Treatment Facility (PRTF) and will meet or exceed standards to operate as a RTC. As soon as permissible, we will petition for initial *Joint Commission* review and file appropriate supporting documents to certify as a PRTF in the State. The process for PRTF certification requires the facility meet the minimum standards to qualify for federal Medicaid reimbursement and is also certified by the *Joint Commission*. We intend to apply for Medicaid reimbursement prior to *Joint Commission* review.

In addition to the above, the academic program at Seasons Residential Treatment will apply to the Maryland State Board of Education for a license to operate as a **Type 1, General Special Education Program**. If approved, we also plan to seek accreditation from *The Middle States*

Association of Colleges and Schools, Commissions on Elementary and Secondary Schools. The State of Maryland Board of Education does not require the additional education accreditation; however, it will provide an additional level of credibility and accountability in the community.

COMAR Standard 10.24.07 G(3)(I) Criminal Background Investigations

Seasons Residential Treatment Program will comply with all regulations outlined in **Family Law Article, §5-560 through §568, Annotated Code of Maryland.** Seasons Residential Treatment will review regulations and **update procedures** governing criminal background investigations for all employees (FT and PT). We have extended this requirement to include all contractors, vendors and volunteers.

Authorized Agent process

Seasons Residential Treatment Program qualifies to become an authorized agent to receive criminal background information based on the services we provide to youth under the age of 18. As soon as permissible and before we hire the first employee, we will:

- 1) Formally petition the State of Maryland Department of Public Safety and Correctional Services Criminal Justice Information Systems Central Repository to become an authorized agent to receive criminal background information;
- 2) Complete Private Party Petition
- 3) Designate an administrator to receive employee background information

Process for pre-employment and annual background check

All employees, contractors, vendors and volunteers who pass the initial interview/screening to work for and conduct business with Seasons Residential Treatment, will be extended a conditional pre-commitment "offer." Pursuant to moving forward, the applicant must successfully complete the following steps:

First step: State of Maryland filing

- 1) Complete and submit an application to the State of Maryland Central Repository and provide identifying information used by the Central Repository to verify and identify the applicant;
- 2) Submit a complete set of legible fingerprints, taken by a designated law enforcement agency or approved agency, to the Central Repository and FBI

Seasons Residential Treatment will:

- 1) Pay for the full background check (State of Maryland and FBI)
- 2) Receive the results directly from the State of Maryland as an authorized agent

Second Step: Outside vendor

Because we are committed to providing effective supervision and treatment of all youth in our care and conducting an orderly and safe facility and program, we will pay for a more comprehensive pre-employment and annual criminal record background check of all applicable staff, volunteers and contractors.

We will retain the services of HireRight a national pre-employment screening services

company to provide pre-employment screening above what is required in the standards set forth in **Family Law Article, §5-560 through §568, Annotated Code of Maryland/COMAR 12.15.02.**

HireRight offers flexible, tailored employment screening solutions, encompassing more than 150 different service offerings, including pre-employment drug screening and background checks for medical professionals. Depending on the job responsibility of the potential employee and in compliance with national and local standards for the type of services we provide, Seasons Residential Treatment will ask for additional screening in the following areas:

- County and **National** Background Check (all employees)
- Employment/Resume Verification (all employees)
- Healthcare Crime check (health care staff – malpractice, license revocation)
- I-9/Immigration Status (all employees)
- Motor Vehicle (all employees)
- Drug and Alcohol Screening (all employees)

COMAR Standard 10.24.07 G(3)(m): Security

At Seasons Residential Treatment, we believe a safe, structured, stable and secure program starts with a well-trained staff. As stated in **COMAR Standard 10.24.07(3)(h)**, Seasons Residential Treatment Program will provide orientation and training for all staff members with respect to administrative procedures, patient rights, confidentiality of resident records, and all relevant policies, procedures and protocols related to environment and community safety.

The entire program will be both staff and hardware secure to meet the needs of the most refractory residents. Each building will have internal and external security cameras. The cameras will be positioned to cover the entire perimeter of the campus and communal areas with the exception of areas of personal hygiene.

All windows and “glass” doors will be shatter proof and all access doors will be secured by fob and key access to control resident movement. All external doors will have a delayed lock system and fob control access to ensure the safety of staff and residents. All cameras will be centrally monitored 24 hours per day, 7 days per week by trained staff. Security staff will also monitor the front/entrance gate.

All residential cottages and the academic building have a dedicated de-escalation room. This room will be used only after alternative options have been considered and attempted and positive behavior supports have been exhausted. The use of this room will follow all federal PRTF regulations (see Exhibit 2) and Code of Maryland standards.

The room will be used as an extreme last resort in the following instances:

- 1) residents who need time to process behaviors with staff, or,
- 2) when it is deemed necessary by staff *and* clinical personnel to remove residents to increase or decrease targeted behaviors

The de-escalation rooms on the residential units are located within line of sight of both the unit therapist and nursing staff. Direct care staff will continue to process with the resident while they are in the de-escalation room to move the resident to the least restrictive environment as soon as safely possible.

4. The Commission will not approve a Certificate of Need unless a facility seeking to establish or expand a service (or construct a new facility) documents that the proposal will not duplicate existing services beyond that allowed by this Plan, and that will not adversely affect existing similar services within the target community.

The proposed program will not duplicate existing services beyond those allowed by the Health Care Commission because our programming fulfills a gap in services for our target population and the clinical intensity of the program we propose is unduplicated in the local market. There are currently more than 750 youth

There are fewer than 150 certified PRTF-level “beds” (see Need above and **Exhibit 10**) in the State of Maryland (and none in the area we propose). Seasons Residential is one of a few programs able to clinically, securely and experientially support tough to treat youth to the age of 21. Our program will leverage evidence-based practices and has a process to systematically track and report resident outcomes as part of our treatment policy and protocol.

We propose there is a significant need for residential beds in the State of Maryland (and surrounding area) for youth with the following presentation:

- Older youth (admission up to age 21) who may be court involved, have serious behavior challenges, are emotionally disturbed;
- Youth with a co-morbid substance abuse problems;
- Youth with severe and long history of trauma whose behaviors may overshadow mental health diagnoses;
- Youth who need a more secure program;
- Youth who need access to credit recovery, educational supports and vocational/career tech training;
- Youth who need accurate, immediate and coordinated care assessment

As supported by data synthesized by the State of Maryland Governor’s Office for Children and referral agencies in the District of Columbia, placing agencies are frequently unable to place our target population in local residential treatment centers. Data shows these youth are often placed with providers far from the youth’s home community. As a result, these youth often have longer lengths of stay in residential care, poor/nonexistent discharge planning, decreased access to community and family based resources and higher recidivism rates/number of residential placements.

We strongly believe the proposed program would be a tremendous asset to the current roster of providers and will improve the overall quality of care to the benefit of the entire community. If approved, Seasons will be able to support youth closer to home and elevate the services available to youth and families in the following ways:

- Provide best-practice, focused care to youth with refractory behaviors
- Provide focused, short-term care (goal for average length of stay is less than 6 months)
- Focus on permanent family/guardianship connections
- Recognize the diverse needs of youth returning to their families and communities
- Develop comprehensive discharge plans that include access to community- based mental health and substance abuse resources
- Concentrate on ensuring school re-enrollment, attendance and success
- Provide real-world workforce preparation for youth over the age of 18
- Employ a staff that understands the social issues plaguing the population served
- Track and report recidivism rates, support youth 18 months post discharge

5. Each organized facility must be able to demonstrate upon request by the Commission, compliance with all mandated federal, state, and local health and safety regulations, and applicable Joint Commission on Hospital Accreditation, other appropriate national accrediting organization standards, or applicable state certification standards unless otherwise exempted by an appropriate waiver.

In accordance with State of Maryland regulations, Seasons Residential Treatment Program, upon approval of the Certificate of Need (CON) application, will immediately petition the Maryland Office of Health Care Quality (OHCQ) of the Department of Health and Mental Hygiene (DHMH) for required RTC licensing in the State of Maryland and will follow steps to become a certified Psychiatric Residential Treatment Facility (PRTF).

Seasons Residential Treatment Program will also immediately meet all mandated federal, state and local health and safety regulations and applicable Joint Commission and Council on Accreditation standards.

Although not required by State of Maryland regulations, in order to most appropriately and completely support the needs of youth with special and general education needs, the education team is committed to meeting the highest standards set forth in all accreditation bodies and will seek accreditation from The Middle States Association of Colleges and Schools, Commissions on Elementary and Secondary Schools.

6. Each facility and organized service provider must institute and/or maintain, and be able to document upon request by the Commission, standardized in-service orientation and continuing education programs, with specified minimum information content, for all categories of direct service personnel, whether paid or volunteer.

Please see **COMAR Standard 10.24.07 G(3)(h) Staff Training**

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY - N/A

CY or FY (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__		20__	20__	20__	20__
1. Admissions							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other							
e. TOTAL							
2. Patient Days							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
3. Average Length of Stay							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
4. Occupancy Percentage*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
5. Number of Licensed Beds*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
6. Home Health Agencies							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. Total patients svcd.							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__		20__	20__	20__	20__
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
7. Hospice Programs							
a. SN visits							
b. Social work visits							
c. Other staff visits							
d.							
e. Total patients srvd.							
8. Ambulatory Surgical Facilities							
a. Number of operating rooms (ORs)							
• Total Procedures in ORs							
• Total Cases in ORs							
• Total Surgical Minutes in ORs**							
b. Number of Procedure Rooms (PRs)							
• Total Procedures in PRs							
• Total Cases in PRs							
• Total Minutes in PRs**							

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.

**Do not include turnover time.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)

CY or FY (Circle)	Projected Years (Ending with first full year at full utilization)			
	2015	2016	2017	2018
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students	14	12	12	12
c. ICF-C/D				
d. Other (PRTF)	62	106	140	152
e. TOTAL	76	118	152	164
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (PRTF)	9,008	18,126	24,227	27,678
e. TOTAL	9,008	18,126	24,227	27,678
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (PRTF)	180	180	180	180
e. TOTAL	180	180	180	180
4. Occupancy Percentage*				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (PRTF)	31%	62%	83%	95%
e. TOTAL	31%	62%	83%	95%

CY or FY (Circle)	Projected Years (Ending with first full year at full utilization)			
	2015	2016	2017	2018
5. Number of Licensed Beds				

a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (PRTF)	80	80	80	80
e. TOTAL	80	80	80	80
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
• Total Procedures in ORs				
• Total Cases in ORs				
• Total Surgical Minutes in ORs**				
b. Number of Procedure Rooms (PRs)				
• Total Procedures in PRs				
• Total Cases in PRs				
• Total Minutes in PRs**				

*Do not include turnover time

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

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a

more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

This project is bound by **COMAR 10.24.07**, however, we strongly believe Seasons Residential Treatment Program will be a more cost effective alternative for many reasons including our ability to help placing agencies in the State of Maryland meet the legislative mandate to keep youth and resources for mental health services in the State.

The population we wish to serve has a history of multiple placements and “failures” in local residential programs, community-based programs and “high-fidelity” wrap around services. The social and financial costs of these failures often lead to escalating behaviors and often result in youth involvement in juvenile services, truancy, or hospitalization. Overall, the costs associated with inappropriate residential placement, missed/masked mental health diagnoses and late onset of adequate clinical resources can be staggering to all stakeholders.

Seasons Residential Treatment will treat youth with refractory behaviors and a long history of trauma. The knowledge, clinical experience and expertise of our round the clock, multi-disciplinary staff may prevent behaviors from escalating to the level an acute hospitalization is needed. We will be second only to inpatient acute hospitalization in the breadth of depth of services we will provide. Our program model is similar to a “sub acute” treatment facility because of the clinical rigor and treatment modalities we will provide.

The average cost for acute hospitalization in the local market is approximately 196% higher than the per diem rate we propose (albeit shorter lengths of stay in acute setting). Youth in acute settings often “step down” to a residential program. Wherever possible, we would want to reduce the need for hospital admission. Consistent with our core principle and treatment philosophy, we are strong advocates of appropriate clinical placement and would never treat a youth who would be better served either at a higher or lower level of care.

We are also a more cost effective alternative because we can treat youth closer to home and will have access to more long-term sustainable resources. Data suggests youth placed far from local resources are at risk for poor family and community reintegration, unsuccessful discharge planning and have a higher rate of recidivism than those placed in the appropriate level of care closer to home.

State of Maryland data suggests one of the reasons many of the youth placed in out of state care were placed far from home was due to the lack of programs to treat older youth (ages 18-21). If approved, we will admit youth up to the age of 21 who would normally be placed in out of state programs.

Seasons Residential Treatment will employ a highly trained and qualified staff. Our evidence-based practices and treatments are proven effective in this target population and our staff is trained to support the most obstinate youth. We want to serve the unique challenges of these youth and their families and have developed a fully integrated, comprehensive, short-term program to maximize therapeutic services before, during and after residential treatment. Our program model includes tracking and reporting post-discharge data and client outcomes. This commitment to support a solid aftercare plan for youth and families also sets our program apart in the local market.

We plan to exceed the highest level of certification standards for a Psychiatric Residential Treatment Facility (PRTF) and meet all requirements for DHMH licensure. We will also adhere to all Joint Commission and national accreditation standards. Our school program will meet standards for Middle States Accreditation and support older youth who may need credit recovery programming, remedial services and vocational/career technical coursework. We plan to partner with local community providers and Core Service Agencies across the state to ensure we are aligned with the most appropriate supports for the youth we serve.

Finally, we agree with national thought leaders who feel residential treatment should remain an important component of an organized system of care, but, should no longer be used as the primary resource to support youth with behavioral problems due to mental health challenges. Our length of stay goals and treatment objectives are consistent with the principles of local and national industry experts.

Our philosophy of communicating, collaborating and cooperating with community stakeholders will set us apart from other programs and providers. Our tagline, "*Transformative Care Rooted In the Community*," is not just marketing copy. Our guiding principles are built around innovation, partnership and collaboration, best in class practices, and long-term positive impact on families and youth suffering from a history of trauma.

Seasons Residential is built on a philosophy of care that will support, identify, build and leverage local community-based resources in order to more effectively and efficiently address the serious and specific challenges confronting local youth. By partnering with community-based programs, we can extend the support beyond our campus and reduce the amount of time youth spend away from their natural resources and shape long term-treatment success. We believe youth are best served in their community with proper stakeholder supports and want to help shape in-state programs that meet current mental health needs of youth and families.

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

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

- a. *Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented. See Exhibit 11*

Seasons Residential Treatment Program is a new organization and has not been operational for the past 2 years. Leading up to the filing of this application, we searched for a partner who has demonstrated a commitment to improving the communities where they are located and by providing children, adults and families with high-quality, trauma-informed behavioral health services and support systems. We have found that in the partnership with Strategic Behavioral Health.

Strategic will acquire Seasons Residential Treatment Program, LLC, if the Commission approves the Certificate of Need and the program is granted a license. In the interim, Seasons will remain privately owned.

Strategic Behavioral Health is a Memphis-based organization with more than 8 behavioral health programs in 4 states and gross revenue of approximately \$83M. Their portfolio includes acute and residential programs and a commitment to healing children, strengthening families and building community. We are excited about our ability to “hit the ground running” under the direction of their experienced leadership team, clinical expertise, evidence-based programming and use of outcomes tools (measurement).

Strategic Behavioral Health brings a host of other tangible and intangible benefits to this market, including tremendous financial resources to improve the physical plant for our residents. Unlike other providers, the organization is also committed to managing admissions and growing the program slowly -- in way that is safe and supportive for all stakeholders.

Please see the two year audited financial statements from Strategic Behavioral Health as a testament to their commitment to this market and to Seasons Residential Treatment Program, LLC.

Seasons Residential Treatment Program has received support from local community providers, referral agencies and related service providers. We have also secured transfer agreements with local acute psychiatric hospitals in the area.

- b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility. (Not Applicable)
- c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

As outlined previously in this application, PRTF-level care and certification requires more clinical staffing, clinical oversight and documentation. The cost and charges for similar services at other facilities in the area will not be adversely affected by the introduction of this project in the local market because there is a gap in the level of programming and type of youth we wish to serve.

We have identified three local providers with similar admissions criteria, generally considered our “competitors.” However, these providers are not currently serving our target population -- tough to treat, older Maryland youth and youth with similar histories of trauma and mental illness referred by agencies in the District of Columbia.

Our per diem rate for therapeutic/residential services will be consistent with rates currently approved and set by federal, state and local jurisdictions. The projected rates are outlined in Tables 2 and 4 (Statistical Projections and Projected Revenue and Expenses) and include the Medicaid rate set by the State of Maryland for PRTF level care in accordance with standards set by the Centers for Medicare and Medicaid.

Reimbursement for education services is based on several factors, including general and special education population mix, length of academic calendar, availability of extended services, type and (behavioral) level of population served and curriculum (i.e.. vocational and career technical courses/certifications). Academic rates are set each year in partnership with the Maryland Department of Education and are generally capped at cost plus 10% for nonpublic school providers.

- d. All applicants shall provide a detailed list of proposed patient charges for affected services. (See attached)

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only. Table 5, "Revenues and Expenses (for the first full year of utilization", is to be completed by each applicant for each proposed service in the space provided. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)

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

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

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__		20__	20__	20__	20__
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
1. Revenue							
a. Inpatient services							
b. Outpatient services							
c. Gross Patient Service Revenue							
d. Allowance for Bad Debt							
e. Contractual Allowance							
f. Charity Care							
g. Net Patient Services Revenue							
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue							

Table 3 Cont. CY or FY (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20__	20__	20__	20__	20__	20__	20__
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies							
j. Other Expenses (Specify)							
k. Total Operating Expenses							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							

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

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT (See Attached)

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

CY or FY (Circle)	Projected Years (Ending with first full year at full utilization)			
	FYE: 12/31/15	FYE 12/31/16	12/31/17	12/31/18
1. Revenues				
a. Inpatient Services	7,091,000	16,916,000	23,010,000	26,934,000
b. Outpatient Services (Day School)	1,080,000	1,200,000	1,200,000	1,200,000
c. Gross Patient Services Revenue	8,981,000	18,116,000	24,210,000	28,134,000
d. Allowance for Bad Debt	(89,810)	(181,160)	(242,100)	(281,340)
e. Contractual Allowance	(4,121,514)	(8,776,266)	(11,309,593)	(13,155,675)
f. Charity Care	-	-	-	-
g. Net Patient Care Service Revenues	4,769,676	9,158,574	12,658,307	14,696,985
h. Total Net Operating Revenue	4,769,676	9,158,574	12,658,307	14,696,985
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	4,239,849	5,946,028	6,872,475	7,210,464
b. Contractual Services	83,924	120,464	144,840	160,536
c. Interest on Current Debt	-	-	-	-
d. Interest on Project Debt	-	-	-	-
e. Current Depreciation	-	-	-	-
f. Project Depreciation	132,000	204,000	240,000	240,000
g. Current Amortization	-	-	-	-
h. Project Amortization	-	-	-	-
i. Supplies	188,601	380,436	508,410	590,814
j. Other Expenses (Specify)				
Advertising	18,000	18,000	18,000	18,000
Recruitment	36,000	36,000	36,000	36,000
Travel	96,000	72,000	72,000	72,000
Repairs	17,962	36,232	48,420	56,268
Rent	456,000	176,000	36,000	36,000
Insurance	48,000	48,000	48,000	48,000

Utilities	132,000	132,000	132,000	132,000
Property Taxes	28,200	28,200	28,200	28,200
Other Expenses	12,000	12,000	12,000	12,000
k. Total Operating Expenses	5,488,536	7,209,360	8,196,345	8,640,282

Table 4 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	2015	2016	2017	2018
3. Income				
a. Income from Operation	(718,860)	1,949,214	4,461,962	6,056,703
b. Non-Operating Income	-	-	-	-
c. Subtotal	(718,860)	1,949,214	4,461,962	6,056,703
d. Income Taxes	-	-	-	-
e. Net Income (Loss)	(718,860)	1,949,214	4,461,962	6,056,703
4. Patient Mix:				
A. Percent of Total Revenue				
1. Medicare	0	0	0	0
2. Medicaid	50%	50%	55%	55%
3. Blue Cross	0	0	0	0
4. Commercial Insurance	2%	2%	4%	4%
5. Self-Pay	3%	3%	3%	3%
6. Other (State/Local Education Authorities)	5%	5%	3%	3%
7. Other Agency Funded/Direct Pay	40%	40%	35%	35%
7. TOTAL	100%	100%	100%	100%
5. Ambulatory Surgical Facilities				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (State/Local Education Authorities)	5%	5%	3%	3%
6. Other: Direct Pay/Agency	40%	40%	35%	35%
7. TOTAL	100%	100%	100%	100%

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

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1995, and their status.

Applicant has never applied for or received a Certificate of Need from the Commission.

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

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

1. an assessment of the sources available for recruiting additional personnel;
2. recruitment and retention plans for those personnel believed to be in short supply;
3. for existing facilities, a report on average vacancy rate and turnover rates for affected positions,

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

This regulation is not required according to Maryland State Health Plan for our project, but, is covered part, by the answer in **COMAR Standard 10.24.07 G (3)(i) Staffing.**

TABLE 5. MANPOWER INFORMATION (See Attached)

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Direct Care					
Support					
				Benefits	_____
				TOTAL	_____

(INSTRUCTION: Indicate method of calculating benefits percentage):

A: If the CON is granted and licensing is approved, Seasons will be acquired by Strategic Behavioral Health. Strategic Behavioral Health currently has a portfolio of acute and residential beds in four states around the country and gross revenues of \$83M. The company currently employs more than 3,000 employees. The size and scope of Strategic Behavioral Health will allow us to provide the best benefits options to our employees at the lowest costs. We calculated the benefits percentage for this project at 23.5% based on the average cost for local employers and included a variable cost savings based on our post-acquisition total payroll and total number of employees.

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

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

Tyeaesis Johnson, 1101 30th Street, NW, 4th Floor, Washington, DC 20007

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

No

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

No

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

No

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

No

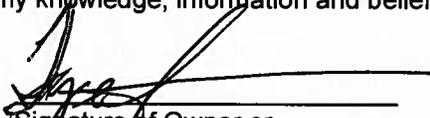
ATTESTATION

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

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

9/3/14

Date



Signature of Owner or
Authorized Agent of the Applicant

Exhibit 1

LEGAL DESCRIPTION

13400 Edgemoade Road, Upper Marlboro, Prince George's County, Maryland, containing approximately 15.16 acres of land, shown as Parcel 48 at Grid C-3 on Prince George's County Tax Map 137, zoned O-S (Open Space) and being more particularly described in a Deed recorded among the Land Records for Prince George's County, Maryland, in Liber 27802, folio 261, et seq., together with improvements thereon.

COUNTY COUNCIL OF PRINCE GEORGE'S COUNTY, MARYLAND
SITTING AS THE DISTRICT COUNCIL
2012 Legislative Session

Bill No. CB-29-2012

Chapter No. 19

Proposed and Presented by Council Member Patterson

Introduced by Council Members Patterson, Davis, Franklin and Lehman

Co-Sponsors _____

Date of Introduction June 19, 2012

ZONING BILL

1 AN ORDINANCE concerning
2 Group Residential Facilities
3 For the purpose of permitting group residential facilities in certain residential zones subject to
4 specific requirements in order to implement the important public purpose of protecting the public
5 safety, health, and welfare; providing local reporting requirements for juvenile group facilities in
6 residential zones, providing enforcement provisions, and repealing the requirement that group
7 residential facilities obtain a special exception as a condition to operating in certain residential
8 zones

9 BY repealing and reenacting with amendments:
10 Sections 27-107.01, 27-441(b) and 27-515(b),
11 The Zoning Ordinance of Prince George's County, Maryland,
12 being also
13 SUBTITLE 27. ZONING.
14 The Prince George's County Code
15 (2011 Edition).

16 BY repealing: Section 27-360,
17 The Zoning Ordinance of Prince George's County, Maryland,
18 being also
19 SUBTITLE 27. ZONING.
20 The Prince George's County Code

(2011 Edition).

BY adding:

Section 27-445.14,

The Zoning Ordinance of Prince George's County, Maryland,
being also

SUBTITLE 27. ZONING.

The Prince George's County Code
(2011 Edition).

SECTION 1. BE IT ENACTED by the County Council of Prince George's County,
Maryland, sitting as the District Council for that part of the Maryland-Washington Regional
District in Prince George's County, Maryland, that Sections 27-107.01, 27-441(b) and 27-515(b)
of the Zoning Ordinance of Prince George's County, Maryland, being also Subtitle 27 of the
Prince George's County Code, be and the same are hereby repealed and reenacted with
amendments:

SUBTITLE 27. ZONING.

PART 2. GENERAL.

DIVISION 1. DEFINITIONS.

Sec. 27-107.01. Definitions.

* * * * *

(109) Group Residential Facility:

~~*~~ (A) A "Dwelling Unit" or "Foster Home," operated by a responsible individual or
organization, which has a program designed to provide a supportive living arrangement for five
(5) or more individuals (unrelated to the operator by blood, adoption, or marriage) who are
members of a service population that, because of age or emotional, mental, physical, familial, or
social conditions, needs supervision.

(B) This term includes, facilities for developmentally disabled persons, drug
dependent persons, alcoholic persons, juveniles, or persons whose welfare and adjustment within
the community are dependent on support from the community.

(C) The term does not include:

[(i) A "Foster Home" where there are four (4) or less persons unrelated by blood,
adoption, or marriage to their foster parents;]

1 [(ii) A "Foster Home" where there are not more than six (6) foster children who
2 are unrelated to their foster parents, but are related by blood or marriage to each other;]

3 [(iii)] (i) A "Hospital" or "Nursing or Care Home";

4 [(iv)] (ii) A "Congregate Living Facility"; or

5 [(v)] (iii) An "Adult Day Care Center."

6 (D) A "Group Residential Facility" for the "mentally handicapped" for up to eight (8)
7 residents shall be considered a "One-family Detached Dwelling."

8 (E) When a "Group Residential Facility" is limited to serving a "mentally
9 handicapped" population, this term shall include any individual with a primary disability as a
10 result of mental retardation, mental illness, or mental disorder which impairs the person's
11 cognitive ability to live independently (excluding addictive disorders resulting from substance
12 abuse).

13 * * * * *

Sec. 27-441. Uses permitted.

(b) TABLE OF USES.

USE	ZONE									
	R-O-S	O-S	R-A	R-E	R-R	R-80	R-55	R-35	R-20	
(6) Residential/Lodging										
* * * * *	*	*	*	*	*	*	*	*	*	
Group residential facility for more than 8 mentally handicapped dependent persons, or for 5 or more other dependent persons [24]	[SE] P									
Group residential facility for not more than 8 mentally handicapped dependent persons	P	P	P	P	P	P	P	P	P	
* * * * *	*	*	*	*	*	*	*	*	*	

[24] All State and private operators of juvenile group residential facilities shall register their facilities with Prince George's County on forms provided by the County. The County shall compile the information and make it available to applicable County agencies.]

USE	ZONE									
	R-T	R-30	R-30C	R-18	R-18C	R-10A	R-10	R-H		
(e) Residential/Lodging										
* * * * *	*	*	*	*	*	*	*	*	*	*
Group residential facility for more than 8 mentally handicapped dependent persons, or for 5 or more other dependent persons ^[94]	[X] P	[X] P	[X] P	[SE] P	[X] P					
Group residential facility for not more than 8 mentally handicapped dependent persons	P	P	P	P	P	P	P	P	P	P
* * * * *	*	*	*	*	*	*	*	*	*	*

[⁹⁴ All State and private operators of juvenile group residential facilities shall register their facilities with Prince George's County on forms provided by the County. The County shall compile the information and make it available to applicable County agencies.]

**PART 8. COMPREHENSIVE DESIGN ZONES.
DIVISION 3. USES PERMITTED.**

Sec. 27-515. Uses permitted.

(b) TABLE OF USES.

USE	ZONE									
	M-A-C	L-A-C	E-I-A	R-U	R-M	R-S	R-L	V-L	V-M	
(7) RESIDENTIAL/LODGING: Group residential facility for up to 8 mentally handicapped dependent persons ^[36]	P	P	[X] P	P	P	P	P	P	P	P
* * * * *	*	*	*	*	*	*	*	*	*	*

[³⁶ All State and private operators of juvenile group residential facilities shall register their facilities quarterly with Prince George's County on forms provided by the County. The County shall compile the information and make it available to applicable County agencies.]

1 SECTION 2. BE IT ENACTED by the County Council of Prince George's County,
2 Maryland, sitting as the District Council for that part of the Maryland-Washington Regional
3 District in Prince George's County, Maryland, that Section 27-360 of the Zoning Ordinance of
4 Prince George's County, Maryland, being also Subtitle 27 of the Prince George's County Code,
5 be and the same is hereby repealed:

6 **SUBTITLE 27. ZONING**

7 **PART. 4. SPECIAL EXCEPTIONS.**

8 **DIVISION 3. ADDITIONAL REQUIREMENTS FOR SPECIFIC SPECIAL**
9 **EXCEPTIONS.**

10 **[Sec. 27-360. Group residential facility.**

11 (a) A group residential facility for more than eight (8) mentally handicapped dependent
12 persons, or for five (5) or more other dependent persons, may be permitted, subject to the
13 following:

14 (1) The applicant shall demonstrate that there is a need for the facility;

15 (2) The premises shall be under supervision at all times; and

16 (3) The regulations set forth in the zone in which the use is proposed may be waived
17 by the District Council provided that:

18 (A) The proposed site is of sufficient size to properly accommodate a facility of
19 the type proposed without adversely affecting adjacent land use; and

20 (B) The waiver is granted in accordance with the requirements and criteria by
21 which variances are granted by the Board of Zoning Appeals (Section 27-230).

22 (b) A statement shall be submitted explaining:

23 (1) The character of the facility;

24 (2) The program's policies and goals, and means proposed to accomplish the goals;

25 (3) The characteristics of the service population and number of residents to be served;

26 (4) The operating methods and procedures to be used; and

27 (5) Any other aspects pertinent to the facility's program.

28 (c) If the subject property is located within a municipality, the municipality shall be
29 allowed sixty (60) days from the date of referral to forward its recommendation to the District
30 Council.]

1 SECTION 3. BE IT FURTHER ENACTED by the County Council of Prince George's County,
 2 Maryland, sitting as the District Council for that part of the Maryland-Washington Regional
 3 District in Prince George's County, Maryland, that Section 27-445.14 of the Zoning Ordinance of
 4 Prince George's County, Maryland, being also Subtitle 27 of the Prince George's County Code,
 5 be and the same is hereby added:

6 **SUBTITLE 27. ZONING**

7 **PART 5. RESIDENTIAL ZONES**

8 **DIVISION 5. ADDITIONAL REQUIREMENTS FOR SPECIFIC USES.**

9 **Sec. 27-445.14 Group residential facility.**

10 (a) A group residential facility for more than eight (8) mentally handicapped dependent
 11 persons, or for five (5) or more other dependent persons, may be permitted, subject to the
 12 following:

13 (1) The applicant shall demonstrate that there is a need for the facility; and

14 (2) The premises shall be under supervision at all times.

15 (b) A statement shall be submitted explaining:

16 (1) The character of the facility;

17 (2) The program's policies and goals, and means proposed to accomplish the goals;

18 (3) The characteristics of the service population and number of residents to be served;

19 (4) The operating methods and procedures to be used; and

20 (5) Any other aspects pertinent to the facility's program.

21 (c) All State and private operators of juvenile group residential facilities are subject to a
 22 reporting requirement. The Department of Environmental Resources, the Police Department,
 23 and the Maryland National Capital Park and Planning Commission shall establish procedures to
 24 implement the reporting requirement for juvenile group residential facilities. The procedures
 25 shall be submitted to the District Council for approval on or before March 15, 2013. The purpose
 26 and intent of reporting by juvenile group residential facilities is to promote the health, safety and
 27 welfare of the citizens and residents of the County to prevent or control the detrimental effects of
 28 juvenile crime in the County.

1 SECTION 4. BE IT FURTHER ENACTED that the provisions of this Act are hereby
2 declared to be severable; and, in the event that any section, subsection, paragraph, subparagraph,
3 sentence, clause, phrase, or word of this Act is declared invalid or unconstitutional by a court of
4 competent jurisdiction, such invalidity or unconstitutionality shall not affect the remaining
5 words, phrases, clauses, sentences, subparagraphs, paragraphs, subsections, or sections of this
6 Act, since the same would have been enacted without the incorporation in this Act of any such
7 invalid or unconstitutional word, phrase, clause, sentence, subparagraph, subsection, or section.

8 SECTION 5. BE IT FURTHER ENACTED that this Ordinance shall take effect forty-five
9 (45) calendar days after its adoption.

Adopted this 24th day of July, 2012.

COUNTY COUNCIL OF PRINCE GEORGE'S
COUNTY, MARYLAND, SITTING AS THE
DISTRICT COUNCIL FOR THAT PART OF
THE MARYLAND-WASHINGTON REGIONAL
DISTRICT IN PRINCE GEORGE'S COUNTY,
MARYLAND

BY: _____
Andrea C. Harrison
Chair

ATTEST:

Redis C. Floyd
Clerk of the Council

KEY:

Underscoring indicates language added to existing law.
[Brackets] indicate language deleted from existing law.
Asterisks *** indicate intervening existing Code provisions that remain unchanged

GUIDE TO ZONING CATEGORIES

PRINCE GEORGE'S COUNTY, MARYLAND



THE MARYLAND-NATIONAL CAPITAL PARK AND PLANNING COMMISSION
PRINCE GEORGE'S COUNTY PLANNING DEPARTMENT

COUNTY ADMINISTRATION BUILDING
14741 GOVERNOR ODEN BOWIE DRIVE
UPPER MARLBORO, MARYLAND 20772

Phone number 301-952-3195

Web Address: www.pgplanning.org

November 2010

RESIDENTIAL ZONES¹

R-O-S: Reserved Open Space - Provides for permanent maintenance of certain areas of land in an undeveloped state, with the consent of the property owners; encourages preservation of large areas of trees and open space; designed to protect scenic and environmentally sensitive areas and ensure retention of land for nonintensive active or passive recreational uses; provides for very low density residential development and a limited range of public, recreational, and agricultural uses.

Minimum lot size - 20 acres*

Maximum dwelling units per net acre - 0.05

* Except for public recreational uses, for which no minimum area is required.

O-S: Open Space - Provides for areas of low-intensity residential (5 acre) development; promotes the economic use and conservation of land for agriculture, natural resource use, large-lot residential estates, nonintensive recreational use.

Standard lot size - 5 acres

Maximum dwelling units per net acre - 0.20

R-A: Residential-Agricultural - Provides for large-lot (2 acre) residential uses while encouraging the retention of agriculture as a primary land use.

Standard lot size - 2 acres

Maximum dwelling units per net acre - 0.50

R-E: Residential-Estate - Permits large-lot estate subdivisions containing lots approximately one acre or larger.

Standard lot size - 40,000 sq. ft.

Maximum dwelling units per net acre - 1.08

Estimated average dwelling units per acre - 0.85

¹ Definitions:

Minimum or Standard lot size: The current minimum net contiguous land area required for a lot.

Average dwelling units per acre: The number of dwelling units which may be built on a tract--including the typical mix of streets, public facility sites and areas within the 100-year floodplain--expressed as a per-acre average.

Maximum dwelling units per net acre: The number of dwelling units which may be built on the total tract--excluding streets and public facility sites, and generally excluding land within the 100-year floodplain--expressed as a per-acre average.

Exhibit 2



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-15

DATE: February 16, 2007
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Psychiatric Residential Treatment Facilities (PRTF) Clarification

Memorandum Summary

- Clarifies that a PRTF, as identified at 42 C.F.R. 483.352, is a separate, stand alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician.
- Reinforces that a PRTF resident population must meet all certification of need requirements as identified under 42 C.F.R. Part 441, Subpart D – Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.
- Reinforces that a PRTF is subject to survey and certification of the entire facility and must meet all requirements under Part 483, subpart G – Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities.

Issue

There has been a recent influx of providers to become certified as PRTFs. Many of these facilities are residential treatment facilities (RTF) or residential treatment centers (RTC) that provide services to children who may need a variety of services, but who may not need the intensive services indicated for those who would be placed in a PRTF. This memo clarifies what is meant by Psychiatric Residential Treatment Facility and the nature of the services it provides for purposes of directing State surveyors.

Historical Development of Psychiatric Residential Treatment Facilities

The Social Security Amendments of 1972 amended the Medicaid statute to, among other things, allow States the option of covering inpatient psychiatric hospital services for individuals under age 21 (Psych under 21-benefit). Originally the statute required that the psych under 21-benefit be provided by psychiatric hospitals. In 1976 final regulations were published implementing the psych under 21-benefit. Section 4755 of the Omnibus Budget Reconciliation Act (OBRA '90) amended section 1905(h) of the Act to specify that the psych under 21-benefit can be provided in psychiatric hospitals that meet the definition of that term in section 1861(f) of the Act "or in another inpatient setting that the Secretary has specified in regulations."

needs of the resident and that according to §441.152 “(2) proper treatment of the resident’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and (3) the services can reasonably be expected to improve the resident’s condition or prevent further regression so that the services will no longer be needed.” As CMS clarified in the 2001 interim final rule (66 FR 28111); payment for inpatient psychiatric services to individuals under age 21 includes the need for room and board as well as the provision of a comprehensive package of services.

PRTF services – who does it serve?

- All PRTF residents according to regulation must need inpatient services to treat his or her psychiatric condition under the direction of a physician and the services provided must be reasonably expected to improve the resident’s condition or prevent further regression so that the services will no longer be needed.
- The psych under 21-benefit is an optional Medicaid benefit. States can determine which psychiatric conditions would fall under this benefit and for which the State will reimburse payment for services rendered. For example, such diagnoses may include paranoid schizophrenia, post-traumatic stress disorder, depression, and/or hyperactivity-attention deficit disorder. Although what psychiatric conditions are covered may differ based on State determinations, (see appendix B), the federal requirements that are established in sections 441.150 through 441.156 must be applied consistently across all States.

PRTFs vs. Residential Treatment Facilities (RTFs) or Residential Treatment Centers (RTCs)

There has been a recent influx of RTFs/RTCs who request to become certified as PRTFs. RTFs or RTCs provide a mixed level of service to children who do not need the intensive services of a PRTF. To be certified as a PRTF, the facility must attest to meeting the Conditions of Participation (CoP) found at 42 C.F.R. Part 483 Subpart G, and attest that all its residents meet the certification of need requirements as identified under 42 C.F.R. Part 441, Subpart D – Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs, as discussed above.

The Social Security Act and federal regulations, expressly identify that services under the psych under 21-benefit can be provided in distinct parts found in psychiatric hospitals; however, a PRTF is not identified as a distinct part of another facility.

Any facility that wishes to be certified as a PRTF must adhere to the following:

1. Survey and Certification review of the entire facility:

Based on CMS standards and existing policy under CMS, the survey process described in the State Operations Manual (SOM), section 2714.1, states that:

The CoPs/Requirements apply to the entire certified provider/supplier and to all patients/residents being served by the certified entity, regardless of payment source unless stated otherwise in the regulations. This means that the surveyors may review the care of private pay patients/residents when surveying a Medicare/Medicaid approved provider or supplier. This policy is based on the premise that it is the provider or supplier

Appendix A: Part 441, Subpart D – Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs, §§ 441.150-441.156.

Sec. 441.150 Basis and purpose.

This subpart specifies requirements applicable if a State provides inpatient psychiatric services to individuals under age 21, as defined in Sec. 440.160 of this subchapter and authorized under section 1905 (a)(16) and (h) of the Act.

Sec. 441.151 General requirements.

(a) Inpatient psychiatric services for individuals under age 21 must be:

(1) Provided under the direction of a physician;

(2) Provided by--

(i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

(ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

(3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following--

(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches 22; and

(4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with Sec. 441.152.

(b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in Sec. 483.352 of this chapter, must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion.

Sec. 441.152 Certification of need for services.

(a) A team specified in Sec. 441.154 must certify that--

(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

(b) The certification specified in this section and in Sec. 441.153 satisfies the utilization control requirement for physician certification in Sec. Sec. 456.60, 456.160, and 456.360 of this subchapter.

Sec. 441.153 Team certifying need for services.

Certification under Sec. 441.152 must be made by terms specified as follows:

(a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that--

(a) The individual plan of care under Sec. 441.155 must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

(b) Based on education and experience, preferably including competence in child psychiatry, the team must be capable of--

(1) Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

(2) Assessing the potential resources of the recipient's family;

(3) Setting treatment objectives; and

(4) Prescribing therapeutic modalities to achieve the plan's objectives.

(c) The team must include, as a minimum, either--

(1) A Board-eligible or Board-certified psychiatrist;

(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

(d) The team must also include one of the following:

(1) A psychiatric social worker.

(2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

(3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.

(4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

State	Criteria – Psych under 21-benefit*	Department	Source of Information
Florida	Minimum criteria: 1. Services can be expected to improve or prevent further regression 2. <u>DSM IV diagnosis</u> 3. A serious impairment in functioning compared to others of the same age due to psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care) 4. Child must be in good physical health	Agency for Health Care Administration	Medicaid Statewide Inpatient Psychiatric Program (SIPP) Services for Individuals Under 18-RFP
Georgia	Psych under 21-benefit is not currently part of State plan **		
Hawaii	Psych under 21-benefit is currently part of State plan – however no information readily available.		
Idaho	Children placed in residential treatment shall meet the CMH (community mental health) eligibility criteria of serious emotional disturbance (SED)	Department of Health and Welfare	Core Services Publication http://www.healthandwelfare.idaho.gov
Illinois	EPSDT	Dept of Children and Family Services	Section 95. Illinois Public Aid Code
Indiana	EPSDT	Indiana Family and Social Services Association	http://www.in.gov/fssa/disability/medicaid/serv.html Online Publication
Iowa	85.3(3) Certification of need of care: 1. Determined by an Independent Team 2. Ambulatory Care services within community not sufficient 3. Care requires supervision by physician 4. Condition is expected to improve or be prevented from further regressing	Department of Human Services	IAC 1/4/06 Chapter 85. Services in Psychiatric Institutions http://www.dhs.state.ia.us/policyanalysis/PolicyManual/Pages/Manual_Documents?Rules/441-85.pdf
Kansas	EPSDT	Dept of Social and Rehabilitation Services	Kansas Health Policy Authority Summary of State Plan Amendment Revisions 06.19.06
Kentucky	EPSDT	Cabinet for Health and Family Services	Directory of Services for Children and Youth with Special Health Care, Educational, and Vocational Rehabilitation Needs. Revised May 2005
Louisiana	Psych under 21-benefit is currently part of State plan – however no information readily available.		
Maine	EPSDT	Department of Health and Human Services	Maine Medical Assistance Manual Psychiatric Facility Services 46.03.1
Maryland	Presence of disorder from the DSM-IV-TR codes on applicable Axes(I-V)	Mental Hygiene Administration	Department of Health and Mental Hygiene MD Per- Susan Steinberg SSteinberg@dhhm.md.us

State	Criteria – Psych under 21-benefit*	Department	Source of Information
Ohio	EPSDT Also known as Healthchek	Department of Job and Family Services	Publication of Ohio legal rights services, January 2006
Oklahoma	EPSDT	Department of Health and Human Services	http://mentalhealth.samsha.gov/Publications/allpubs/State_Med/Oklahoma.pdf
Oregon	EPSDT	Department of Human Services, Mental Health, and Disability Services	Oregon Administrative Rule 309-031-0200 Mental Health and Developmental Disability Services Division Administrative Rules OAR 309-031-0200 through 309-031-0255
Pennsylvania	EPSDT	Department of Public Welfare	Pennsylvania Code- Ch.1241
Rhode Island	EPSDT	Department of Human Services	Provider Update July 2002, vol 1117
South Carolina	EPSDT	Department of Human Services	South Carolina State Subsidy Plan
South Dakota	Psych under 21-benefit is not currently part of State plan **		
Tennessee	EPSDT	Department of Mental Health & Developmental Disabilities Office of Managed Care	TennCare Medicaid Brief Chapter 1200-13-13 Manual for Mental Health Coverage to Uninsured Tennesseans January 2006
Texas	EPSDT determines Medical Necessity	Department of Health and Human Services	Texas Administrative Code Title 25 Ch. 38, Rule 38.4 Children with Special Health Care Needs Services Programs (CSHCN).
Utah	CHEC screening, also known as EPSDT	Department of Health	Scope of Services (Article III) section of Utah's contract with Prepaid Mental Health Plans
Vermont	EPSDT	Department of Health; Agency of Human Services	www.vermont.gov
Virginia	Psych under 21-benefit is not currently part of State plan **		
Washington	Psych under 21-benefit is currently part of State plan – however no information readily available.		
West Virginia	PRTFs are long term treatment facilities that treat clients with, severe, complex symptoms, of a significant duration, that have not responded to other level of care. These admissions require pre-approval. They require an MCM-1 and other supportive documentation such as psychiatric evaluations, psychosocial evaluations, social summaries, progress reports, MDT notes, or any documentation that would support why the client needs long term psychiatric residential treatment.		Source: https://secure.wvmi.org/Priorauth/priorauth/PRTF_Children_under21.pdf
Wisconsin	Psych under 21-benefit is currently part of State plan – however no information readily available.		
Wyoming	Psych under 21-benefit is not currently part of State plan **		

* References to **EPSDT** means Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals under age 21 (42 C.F.R. Part 441 – Subpart B).

** DHHS, CMS source: Medicaid At-A-Glance 2005. (See <http://www.cms.hhs.gov/medicaid/stateplans>).

- (1) Includes a physician;
- (2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
- (3) Has knowledge of the individual's situation.

(b) For an individual who applies for Medicaid while in the facility of program, the certification must be--

- (1) Made by the team responsible for the plan of care as specified in Sec. 441.156; and
- (2) Cover any period before application for which claims are made.

(c) For emergency admissions, the certification must be made by the team responsible for the plan of care (Sec. 441.156) within 14 days after admission.

Sec. 441.154 Active treatment.

Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care, described in Sec. 441.155 that is--

- (a) Developed and implemented no later than 14 days after admission; and
- (b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

Sec. 441.155 Individual plan of care.

(a) "Individual plan of care" means a written plan developed for each recipient in accordance with Sec. Sec. 456.180 and 456.181 of this chapter, to improve his condition to the extent that inpatient care is no longer necessary.

(b) The plan of care must--

- (1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;
- (2) Be developed by a team of professionals specified under Sec. 441.156 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;
- (3) State treatment objectives;
- (4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
- (5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

(c) The plan must be reviewed every 30 days by the team specified in Sec. 441.156 to--

- (1) Determine that services being provided are or were required on an inpatient basis, and
- (2) Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

(d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for--

- (1) Recertification under Sec. Sec. 456.60(b), 456.160(b), and 456.360(b) of this subchapter; and
- (2) Establishment and periodic review of the plan of care under Sec. Sec. 456.80, 456.180, and 456.380 of this subchapter.

Sec. 441.156 Team developing individual plan of care.

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the latest issuance of the State Operations Manual issued by CMS (CMS Pub. 7).

(h) *State MDS system and database requirements.* As part of facility agency responsibilities, the State Survey Agency must:

(1) Support and maintain the CMS State system and database.

(2) Specify to a facility the method of transmission of data, and instruct the facility on this method.

(3) Upon receipt of facility data from CMS, ensure that a facility resolves errors.

(4) Analyze data and generate reports, as specified by CMS.

(i) *State identification of agency that receives RAI data.* The State must identify the component agency that receives RAI data, and ensure that this agency restricts access to the data except for the following:

(1) Reports that contain no resident-identifiable data.

(2) Transmission of reports to CMS.

(3) Transmission of data and reports to the State agency that conducts surveys to ensure compliance with Medicare and Medicaid participation requirements, for purposes related to this function.

(4) Transmission of data and reports to the State Medicaid agency for purposes directly related to the administration of the State Medicaid plan.

(5) Transmission of data and reports to other entities only when authorized as a routine use by CMS.

(j) *Resident-identifiable data.* (1) The State may not release information that is resident-identifiable to the public.

(2) The State may not release RAI data that is resident-identifiable except in accordance with a written agreement under which the recipient agrees to be bound by the restrictions described in paragraph (i) of this section.

[62 FR 67212, Dec. 23, 1997, as amended at 74 FR 40363, Aug. 11, 2009]

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Subpart G—Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

SOURCE: 66 FR 7161, Jan. 22, 2001, unless otherwise noted.

§ 483.350 Basis and scope.

(a) *Statutory basis.* Sections 1905(a)(16) and (h) of the Act provide that inpatient psychiatric services for individuals under age 21 include only inpatient services that are provided in an institution (or distinct part thereof) that is a psychiatric hospital as defined in section 1861(f) of the Act or in another inpatient setting that the Secretary has specified in regulations. Additionally, the Children's Health Act of 2000 (Pub. L. 106-310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 as defined by sections 1905(a)(16) and (h) of the Act.

(b) *Scope.* This subpart imposes requirements regarding the use of restraint or seclusion in psychiatric residential treatment facilities, that are not hospitals, providing inpatient psychiatric services to individuals under age 21.

§ 483.352 Definitions.

For purposes of this subpart, the following definitions apply:

Drug used as a restraint means any drug that—

(1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;

(2) Has the temporary effect of restricting the resident's freedom of movement; and

(3) Is not a standard treatment for the resident's medical or psychiatric condition.

Emergency safety intervention means the use of restraint or seclusion as an

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occur while the resident is in the program;

(2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;

(3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

(4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

(d) *Contact information.* The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

§ 483.358 Orders for the use of restraint or seclusion.

(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under age 21 be provided under the direction of a physician.

(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion.

(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety

intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(e) Each order for restraint or seclusion must:

(1) Be limited to no longer than the duration of the emergency safety situation; and

(2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.

(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to—

(1) The resident's physical and psychological status;

(2) The resident's behavior;

(3) The appropriateness of the intervention measures; and

(4) Any complications resulting from the intervention.

(g) Each order for restraint or seclusion must include—

(1) The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;

(2) The date and time the order was obtained; and

(3) The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

(h) Staff must document the intervention in the resident's record. That documentation must be completed by

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(d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

§483.366 Notification of parent(s) or legal guardian(s).

If the resident is a minor as defined in this subpart:

(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

§483.368 Application of time out.

(a) A resident in time out must never be physically prevented from leaving the time out area.

(b) Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).

(c) Staff must monitor the resident while he or she is in time out.

§483.370 Postintervention debriefings.

(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s).

The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of—

(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;

(2) Alternative techniques that might have prevented the use of the restraint or seclusion;

(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

§483.372 Medical treatment for injuries resulting from an emergency safety intervention.

(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that—

(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

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(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.

(g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

(h) All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency.

Subpart H [Reserved]

Exhibit 3



CLARIFICATION AND ASSUMPTIONS

Seasons Residential Treatment Program, Upper Marlboro, MD
Conceptual Cost Option

May 2014
PI4-579

We propose a Conceptual Cost Opinion of **\$2,093,098** (Two Million Ninety Three Thousand Ninety-Eight Dollars) to perform the construction renovations and alterations for the Seasons Residential Treatment facility in Upper Marlboro, MD. Budget pricing is based on the following clarifications and these items:

- As-built Drawings dated 5/7/2007 & Residential Pod Layout Markup Sheet
- Onsite Walk-thru
- Thomas Construction Group Clarifications & Assumptions dated May 13, 2014
- Schedule of Values dated May 13, 2014
- Cottage Layout Drawing dated May 12, 2014
- Proposed Site Layout dated May 8, 2014

General Assumptions, Inclusions and Exclusions:

1. We have included the following:
 - a. Allowance of 0.5% of project total for all building permit fees.
 - b. Architectural design fees.
 - c. Draining and backfilling the pool only (all other work associated to pool and associated building is excluded).
 - d. We have only included renovation of one (1) cottage building. There are four (4) total on campus.
2. We have excluded the following:
 - a. Temporary and permanent utilities. We assume that use of existing building utilities will be allowed during construction.
 - b. Payment and performance bonds.
 - c. All material testing and/or special inspections.
 - d. All exterior improvements, except those specifically listed on the cost opinion breakdown.
 - e. Adding a new irrigation system.
 - f. Adding fire protection systems with the exception of the Cafeteria building. We assume other buildings will not require fire protection systems as they are being re-purposed with similar use of previous occupancies.
 - g. Security systems and CCTV. We would need to develop a specific program for this facility in order to provide budget pricing.
3. We also exclude the following:
 - a. All new buildings HVAC equipment (to be replaced by Seller).
 - b. All work required to mitigate water intrusion in basement of Classroom Building to be complete by Seller).
 - c. Trailer and any other unused existing buildings on campus will remain in "as is" condition (no work).
4. Our renovations are limited to selective architectural renovations except at the Cottage and Cafeteria.
5. We recommend a life safety and ADA Code analysis prior to finalizing budget.

Building A: Conversion/renovation of former classroom building to accommodate administrative offices; will include cubicles and workstations for several departments and functional areas:

1. Minor architectural renovation. Provide new flooring and paint existing partitions, as required for new layout.
2. Re-use all existing doors, frames and hardware as required. Existing frames and doors to be repaired as is with only minimal scraping of peeling paint.
3. Install ¼" clear Lexan polycarbonate window protection at all existing exterior windows.



Building B: Residential Cottages (A-D): Renovation of four (4) existing residential cottages (**Reference Cottage Layout Section**)

1. Demolition of interior building as required for proposed layout.
2. Saw cut existing concrete slab and infill for new plumbing lines.
3. We have included a \$220,000 allowance to provide new plastic laminate millwork and counter tops at nurse's station, restrooms and consult office.
4. Provide new doors, frames, and hardware at bedrooms, nurse's station, seclusion room and restrooms. Includes seclusion room hardware set, steel frame, view port glass and security mirror. All other existing doors, frames and hardware are to remain for re-use.
5. Provide ¼" clear Lexan polycarbonate window protection at all exterior windows.
6. Provide new partitions and VHI board as required for proposed layout.
7. Prep and patch existing gypsum board walls and prepare for paint.
8. Provide new hard ceilings as required.
9. Paint existing partitions and new ceilings.
10. Install new floor coverings as required.
11. Provide new restrooms, including fixtures and piping
12. Provide security grills as required. Assume tie-in and re-use of existing HVAC equipment and ductwork.
13. Re-use of existing electrical, sprinkler and fire alarm systems. Provide new security light fixtures as required.
14. Provide access control key FOB entry system at two (2) existing exterior door locations.

Building C: Administration and School Building: Renovation of existing school and administrative building to accommodate administrative offices, classrooms, recreational space (movement therapy), vocational instruction:

1. Mirror architectural renovation. Provide new flooring and paint existing partitions as required for new layout.
2. Re-use all existing doors, frames and hardware as required. Existing frames and doors to be repaired, with only minimal scraping and peeling of paint.
3. Re-use existing ceiling systems throughout. We have included a \$5,000 allowance to replace 25% of existing ceiling tiles.
4. Inspect clean and reuse existing HVAC system, ductwork, registers, grilles, and diffusers as required.
5. Re-use of existing electrical systems, fire alarm systems and light fixtures throughout.
6. Provide access control key FOB entry system at four (4) existing exterior door locations.

Building D: Cafeteria: Complete renovation of cafeteria building

1. Demolish floor finishes, ceilings, millwork, partitions, and all existing MEP systems throughout.
2. Saw cut existing concrete slab and infill for new plumbing lines.
3. \$5,000 allowance for structural repair.
4. Patch and replace existing roofing.
5. Install new doors, frames, and hardware throughout.
6. Install 1/4" clear Lexan polycarbonate window protection at all exterior windows.
7. Install new floor coverings throughout.
8. Install new hard ceilings throughout.
9. Paint partitions and ceilings throughout.
10. We have included an Allowance of \$110,000 for new kitchen equipment and ansul system for fire suppression. Assume specialty equipment may be needed to fit existirg space.

Exterior Improvement: Exterior work to be performed to complete campus

1. An Allowance of \$50,000 to repair existing ADA access ramps and landscape entry feature.
2. An Allowance of \$20,000 for automatic security gates and openers at main entrance of campus.
3. An Allowance of \$60,000 for approximately 1,840 LF of 10' high chain link security fence with wind screen.
4. An Allowance of \$15,000 to drain existing pool and back fill opening with suitable fill material.



General Terms and Offerings:

Allowance Defined: Allowance is a sum which if costs exceeds, the Owner is to reimburse the Contractor the difference between cost and allowance; if the cost is less than allowance, the Contractor is to reimburse the Owner the difference between cost and allowance.

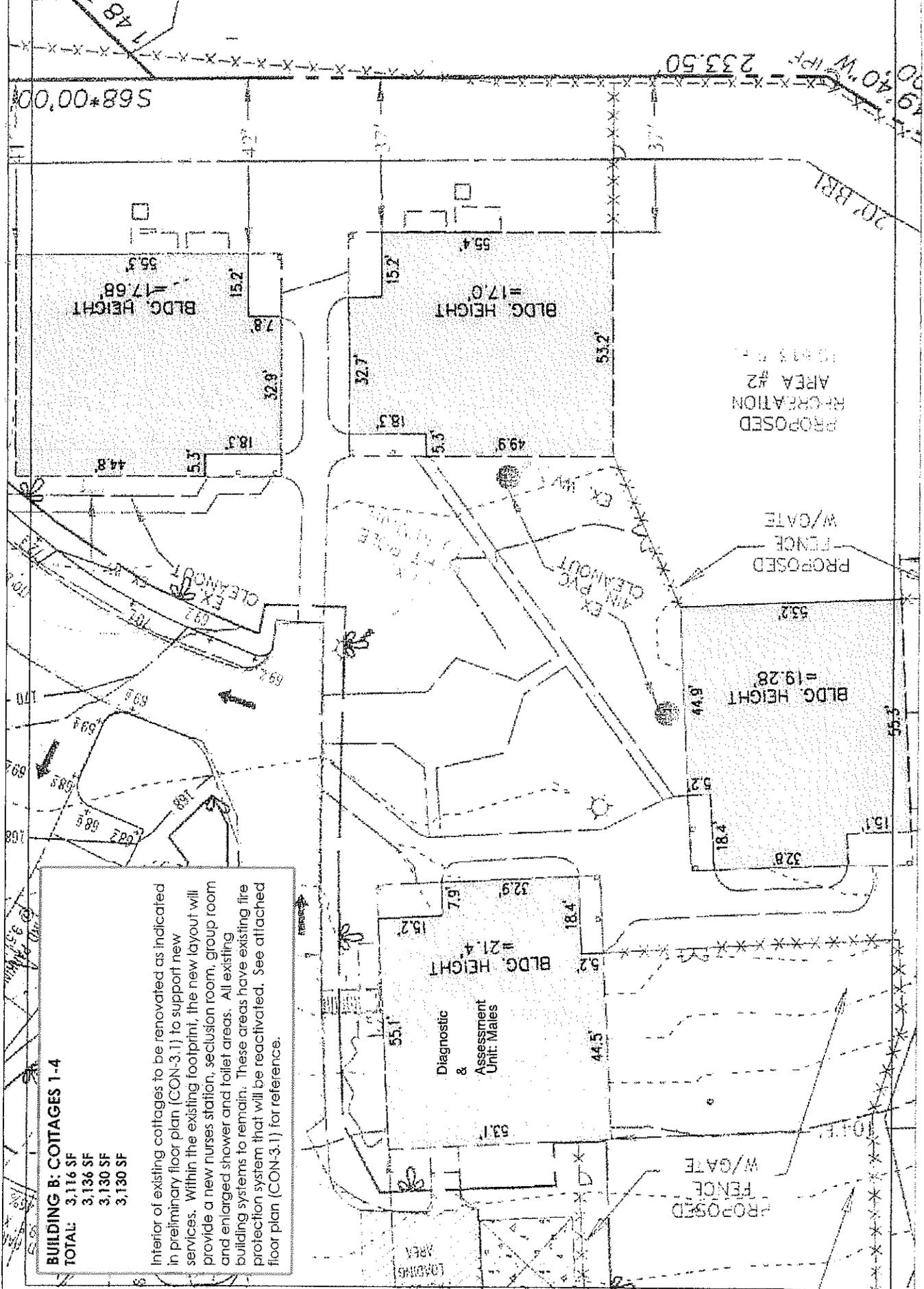
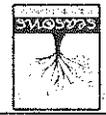
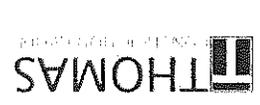
Limitations: Work is limited to the areas outlined above.

Unusual Conditions: Any unusual subsurface conditions (rock, water, unsuitable soils, etc.) regarding site preparations shall be charged extra and the contractor shall advise the Owner prior to commencing construction and/or when such unusual conditions become evident as to the extent and price of said extras.

Plans and Specifications: The work shall be performed strictly in accordance with drawings, plans and specifications and no alterations shall be made therein, except upon written order signed by both parties, which order shall specify the amount to be added to or deducted from the contract price by reason of such alterations. Unless specified otherwise, proposal includes standard colors from respective vendors.

CON-3.0
 SCALE: 1" = 20'-0"
 Seasons - Upper Marlboro
 08/12/14
 BLDG B - COTTAGE - SITE PLAN

THOMAS
 ARCHITECTURAL & ENGINEERING
 1800 WASHINGTON BLVD, SUITE 200
 WASHINGTON, DC 20037
 (202) 462-1550
 www.thomasarchitect.com



BUILDING B: COTTAGES 1-4

TOTAL	3,116 SF
	3,136 SF
	3,130 SF
	3,130 SF

Interior of existing cottages to be renovated as indicated in preliminary floor plan (CON-3.1) to support new services. Within the existing footprint, the new layout will provide a new nurses station, seclusion room, group room and enlarged shower and toilet areas. All existing building systems to remain. These areas have existing fire protection system that will be reactivated. See attached floor plan (CON-3.1) for reference.

PROPOSED RECREATION AREA #2

49'40" W.H.P. = 233.50'

20' BBL

PROPOSED FENCE W/GATE

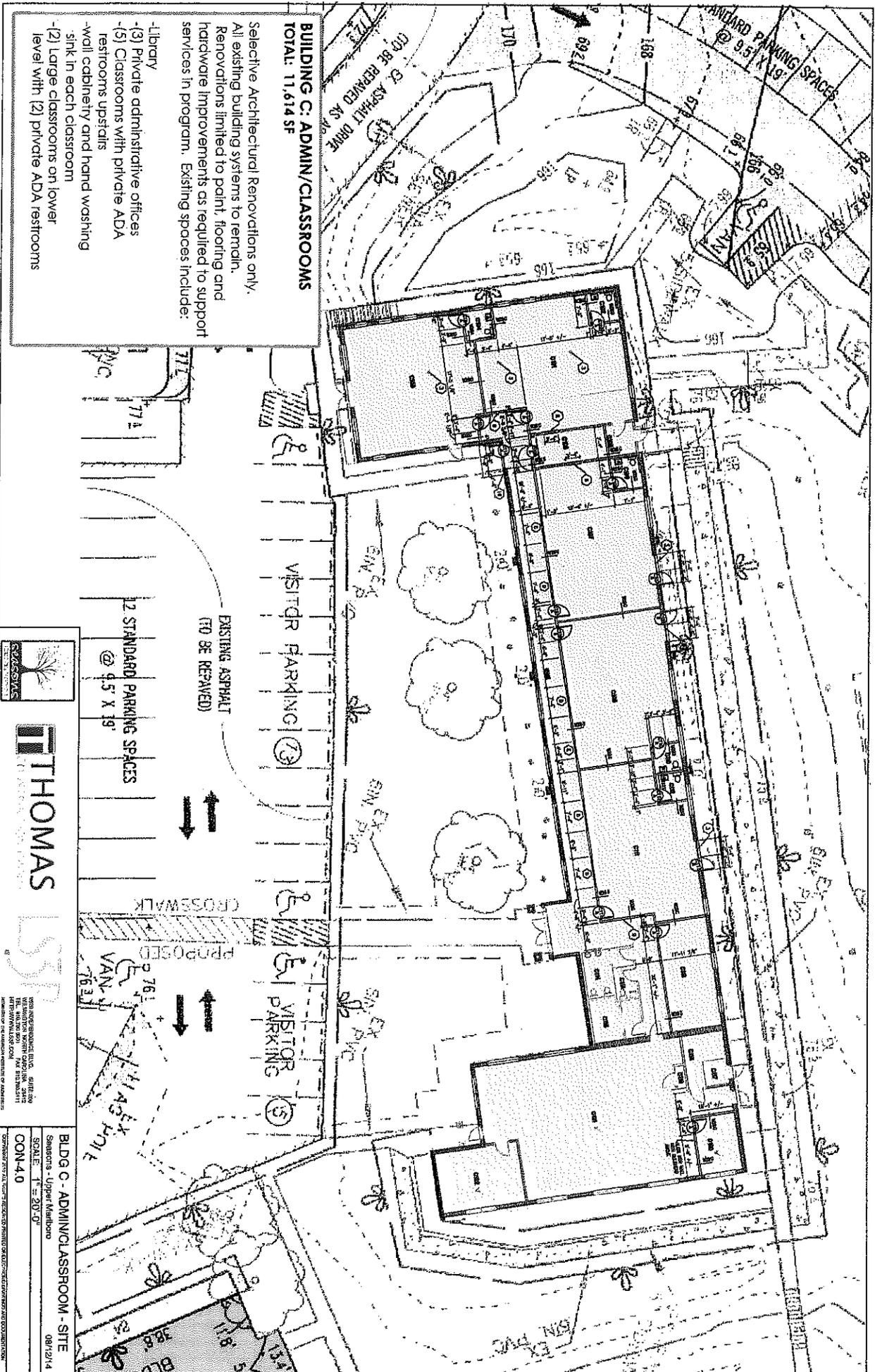
BLDG HEIGHT = 19.28'

BLDG HEIGHT = 21.4'

Diagnostic & Assessment Unit: Males

PROPOSED FENCE W/GATE

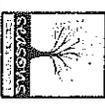
LOADING AREA



BUILDING C: ADMIN/CLASSROOMS
TOTAL: 11,614 SF

Selective Architectural Renovations only.
 All existing building systems to remain.
 Renovations limited to paint, flooring and hardware improvements as required to support services in program. Existing spaces include:

- Library
- (3) Private administrative offices
- (5) Classrooms with private ADA restrooms upstairs
- wall cabinetry and hand washing sink in each classroom
- (2) Large classrooms on lower level with (2) private ADA restrooms

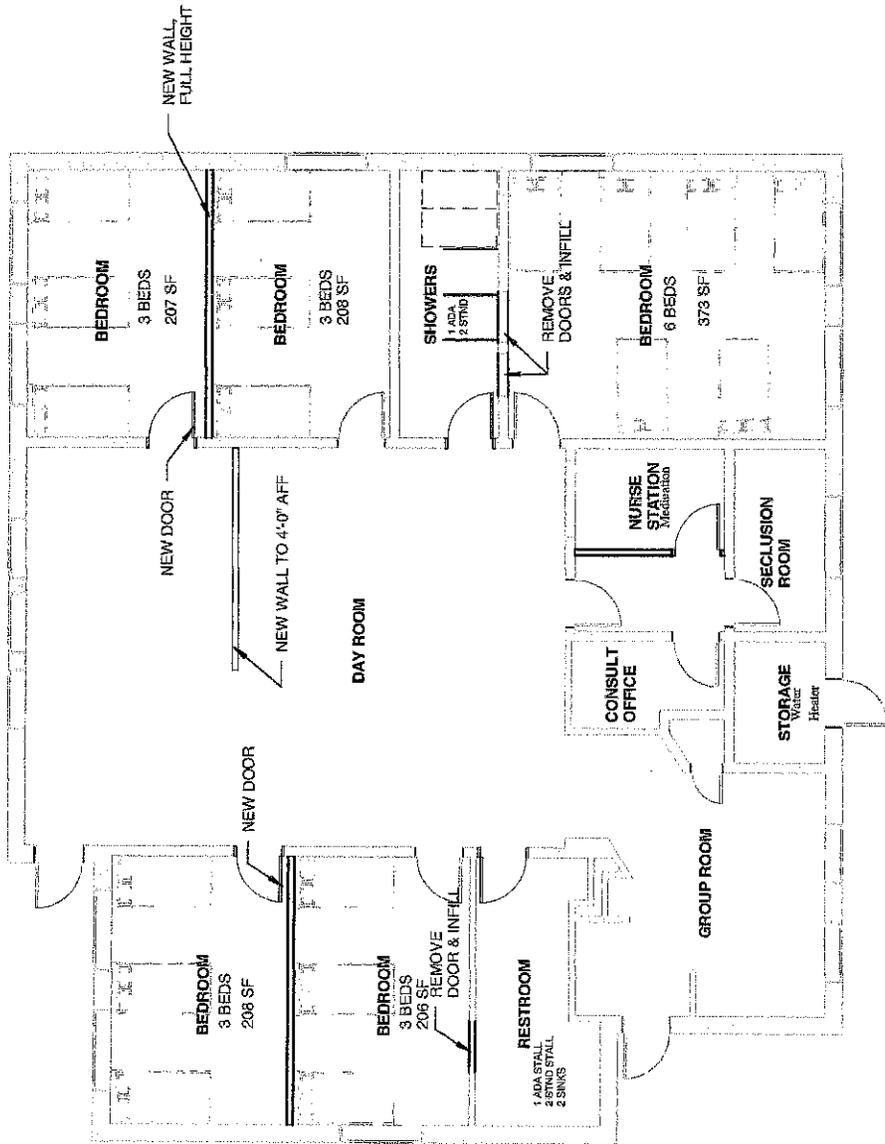


THOMAS
 CONSTRUCTION SERVICES

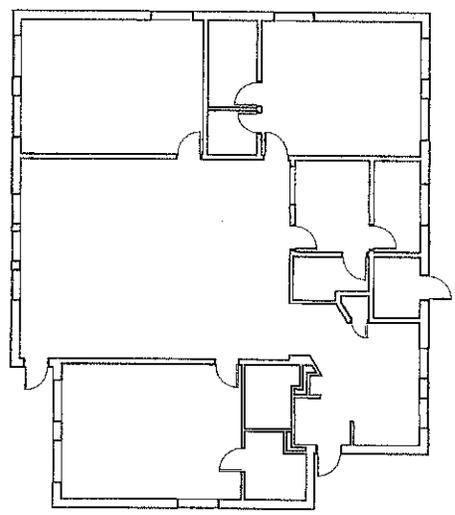


S.P. CONSTRUCTION SERVICES
 100 WASHINGTON NORTH CORRIDOR, SUITE 200
 WASHINGTON, NORTH CAROLINA 27681
 TEL: 919.487.1000 FAX: 919.487.1001
 WWW.SP-CONSTRUCTION.COM

BLDG C - ADMIN/CLASSROOM - SITE
 Seasons - Upper Marlboro
 SCALE: "1" = 20'-0"
 CON-4.0
 08/7/14



2 SCHEMATIC FLOOR PLAN
1/8" = 1'-0"



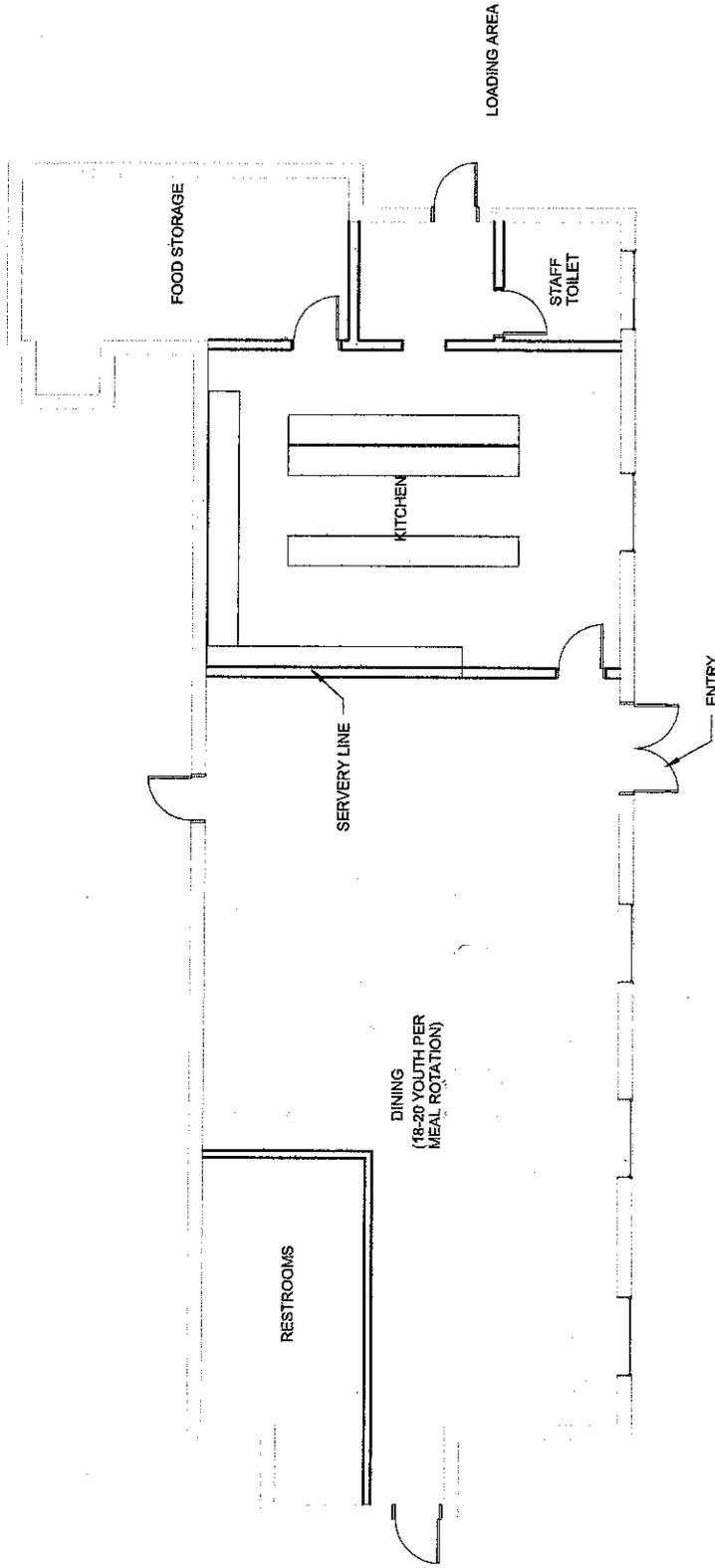
1 EXISTING FLOOR PLAN
1/16" = 1'-0"

BLDG B - COTTAGE - FLOOR PLAN
Seasons - Upper Marlboro
SCALE: As Indicated
CON-3.1
08/12/14

THOMAS LSP

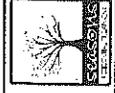
THOMAS LSP ARCHITECTS, INC.
10000 WOODBURN BLVD. SUITE 200
UPPER MARLBORO, MD 20786
TEL: 410-326-0101 FAX: 410-326-1111
WWW.TLSP.COM

REGISTERED ARCHITECTS AND DESIGNERS
REGISTERED PROFESSIONAL LANDSCAPE ARCHITECTS



1 SCHEMATIC FLOOR PLAN

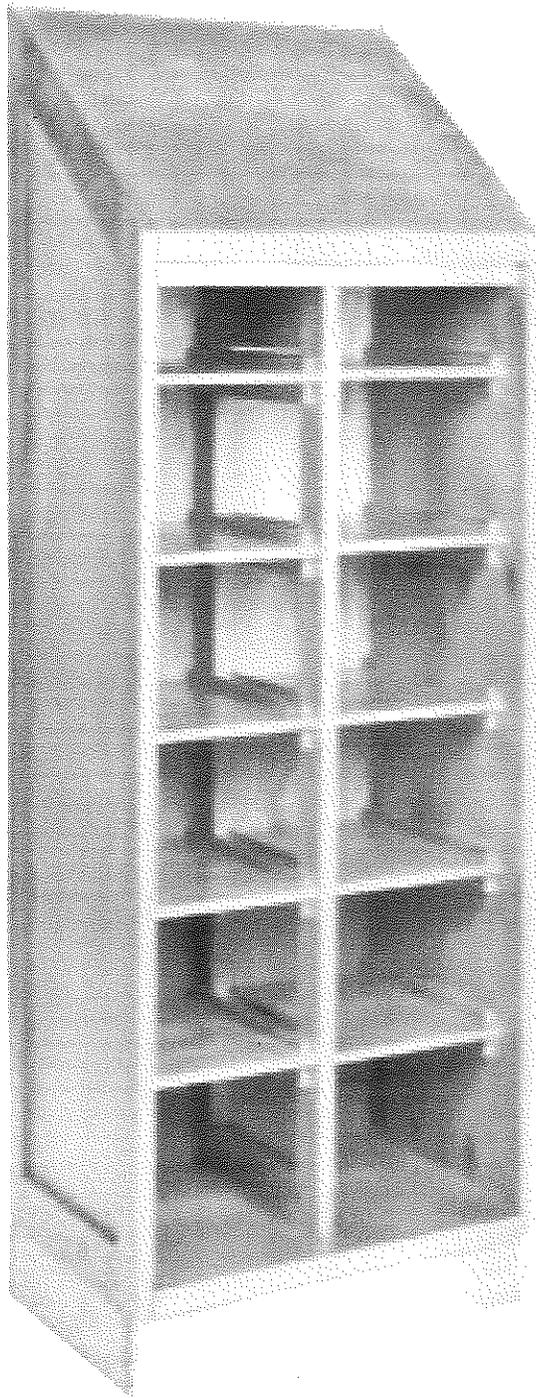
1/8" = 1'-0"



2220 INDEPENDENCE BLVD., SUITE 200
 WILMINGTON, DE 19804
 TEL: 302.478.1111
 FAX: 302.478.1111
 WWW.THOMAS-CE.COM

DATE: 08/12/14
 SCALE: 1/8" = 1'-0"
 CON-5.1

BLDG D - DINING HALL - FLOOR PLAN
 Seasons - Upper Meriboro
 CONFIRMED BY ALL APPLICANTS AND REVIEWED BY ALL APPLICANTS
 AND APPROVED BY ALL APPLICANTS AND REVIEWED BY ALL APPLICANTS



09027 Large Slope Top
Wardrobe

36"L x 23"D x 80"H

Exhibit 4

WOOSTER DRILLING CO.

WATER WELL DRILLING AND SERVICES

United Bank

Attn: Cindy Bartnick
P-703-449-1278

March 15, 2012

Ref: Replacement Well at Henson Valley Montessori School

Dear Madam:

We propose to furnish all materials, to perform all labor, to supply all machinery and to provide for all insurance necessary to complete a water well under the following terms and conditions:

1. Said well is to be 4-1/2 inches in diameter and approximately 400 feet deep, complete with all SDR-17 plastic pipe, proper stainless steel screen, a 30 gallon per minute 3/4 HP, submersible pump installed on 2 inch galvanized pipe, and all lines, ditches and controls for above system. Price to include new drop pipe, double insulated wires, and commercial pitless adaptor.

2. Wooster Drilling Company represents that the well when completed and equipped with the aforesaid pump will produce not less than 30 gallons of water per minute or 1800 gallons per hour when pumped to its capacity. Wooster Drilling Company further warrants that the well will conform to all state and local regulations and will be properly chlorinated. Please note: Several chlorinations may be necessary to bring the well to health department standards for bacteria.

3. All of the work is to be completed in a good and workmanlike manner according to standard practices in the industry. Wooster Drilling Company expressly warrants that all materials and equipment supplied shall be of merchantable quality and warrants that should the well system fail to operate between installation of the pumping system and 12 months thereafter for any reason, excluding accidental or malicious damage, floods, earthquakes, hurricanes, electrical storms or other acts of nature, Wooster Drilling Company agrees to service the affected area at no additional cost to customer for labor or materials.

4. The total cost of the above work shall be \$17,000.00, plus a \$ 80.00 permit fee provided however that there shall be an additional charge of \$12.00 per foot for any well deeper than 500 feet. There shall be an additional charge of \$4.00 per foot for any line between the well and water tank in excess of 25 feet. Customer agrees to pay this amount as follows:

- I. \$2,500.00 upon moving equipment on site.
- II. \$13,000.00 upon completion of drilling operation.
- III. \$ 1,500.00 upon the installation of the pump, and lines.
- IV. The additional charges, if any, for any well deeper than 500 feet and for any additional line shall be paid upon pump installation.

5. Customer agrees to provide Wooster Drilling Company adequate space in which to carry out its normal drilling operations, provide proper electrical power to the area of the water tank, and that Wooster Drilling Company is not responsible for any settling of ditches, any excess dirt left on the property or damage to lawns or trees as a result of normal drilling operations.

6. Customer agrees that should it become necessary for Wooster Drilling Company to institute legal proceedings to collect the compensation for the work performed, then the customer shall be liable for expenses incurred in same, including attorney's fees, which said fee shall be 25% of the contract price herein, court costs, and interest rate of 1-1/2% per month. Wooster Drilling Company may, at their option, remove any or all of the above water system for non-payment.

These prices are in effect for a period of 120 days from the above date. If the above conditions are satisfactory, please sign the duplicate copy and return it to the address below.

7. Please check (✓) if you wish to have your old well abandoned and sealed for an additional cost of \$650.00.

8. Please check (✓) if you wish to have your water tested by an independent Lab for an additional cost of \$200.00. This fee covers two tests, which are required by law. The Health Department may provide these services that are included in your permit fee, however, their time frame may not meet your needs for company or use of your water for potable purposes.

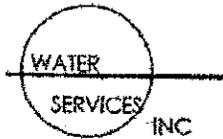
Date (Customer)

C. Bartnick 5/4/12
Date (Customer)

SVF-Facilities Director

Larry Wooster
Larry Wooster, Owner
Wooster Drilling Company

SCOPE OF WORK FOR SEWAGE SYSTEM ATTACHED BEHIND



Copy

14 E Irongate Drive
Waldorf, Maryland 20602

301.645.2798...phone
301.705.5734...fax

May 9, 2012

CONTRACT FOR SERVICES
BY AND BETWEEN WATER SERVICES, INC. AND UNITED BANK

Water Services, Inc. located at 14-E Irongate Drive, Waldorf, MD 20602 (herein after known as "WSI") and United Bank located at 14226 Albermarle Point Place, Suite 100, Chantilly, VA 20151 (herein after known as "The Bank") through their duly appointed representatives agree to the terms and conditions specified in this contract.

"WSI" and "The Bank" specify that the representative signing the contract has the authority to enter into binding agreements on behalf of "WSI" and "The Bank".

"WSI" and "The Bank" specify that all current or future owners, assignees, stockholders, and board of directors shall be bound by the terms and conditions specified and agreed to in this contract.

"WSI" and "The Bank" specify that bankruptcy shall not be grounds to nullify the terms and obligations specified in this contract.

Failure to abide by the terms of this contract by either signatory, shall result in default by that signatory. The defaulting signatory shall be responsible for all court costs, legal fees, and all reasonable costs incurred to enforce the terms of this contract.

"WSI" shall maintain workmans comp insurance and liability insurance providing "The Bank" with a copy upon request;

"WSI" shall provide all materials and labor necessary to perform the work specified in the contract;

"WSI" shall follow safe work practices as specified by OSHA and MOSH;

"WSI" shall hold harmless and indemnify "The Bank" against any claims resulting from the work performed by WSI in the execution of this contract.

"WSI" shall perform the services listed herein. Required service shall be limited to the scope of work specified in this contract.

"WSI" shall;

I Paint

- A) Sand blast all exposed surfaces of all accessible tanks to bare metal, using silica free abrasive.
- B) Paint all exposed surfaces of all accessible tanks. Using a two part epoxy paint specified as suitable paint by the manufacturer representative (Dura-Plate 235 multipurpose epoxy).

II Laboratory

- A) Return to operation status, the sump pump and pit, used to pump water discharged from the lab sink.

III Surge Tank

- A) Replace two (2) 1/2 hp 230 volt 2" sewage pumps located in the influent tank.
- B) Pipe two (2) influent pumps to the distribution box.
- C) Rewire two (2) influent pumps and four (4) associated control floats in approved conduits and wire appropriately sized to carry current voltage of blower units.
- D) Repair flow control weir located at influent chamber.
- E) Provide minor structural repairs, limited to support beams for wiring supports and grate supports.

IV Aeration

- A) Replace one (1) 33 URAI Roots blower for the aeration system.
- B) Inspect and repair the air distribution lines for the aeration system, making repairs as needed. To include galvanized piping to the influent chamber, aeration chamber, and clarifier including air headers.
- C) Replace air diffuser in the aeration system.
- D) Inspect and make repairs to (pipe and pipe fittings as needed) the sludge return system.

E) Test and repair wiring circuits, starters and relays to existing control panel, located at the aeration tank.

F) Provide minor structural repairs, limited to support beams for wiring supports and grate supports.

V Nitrification Tower

A) Replace recirculation pump.

B) Repair electrical housing for recirculation pump.

C) Replace control floats for recirculation pump.

D) Inspect and repair spray system for nitrification tower.

VI Filter System, Disinfection, Composite Sampler and Flow Meter/Recorder

A) Replace one (1) 33 URAI blower and motor for post aeration and air source.

B) Replace, as needed any pipe, fittings, and valves required to return air system to manufacturers specifications for operation.

C) Replace one (1) composite sampler (meeting NPDES permit requirements).

D) Wire one (1) composite sampler electrically and wire to interface with the ultra sonic flow meters.

E) Replace one (1) ultra sonic flow meter.

F) Replace one (1) seven day chart recorder.

G) Disassemble and repair two (2) multimedia filters to include replacing strainers, filter media and piping.

H) Replace one (1) disinfection system with a system capable of treating 10,000 gpd flow with BOD concentrations of 20 mg/L and TSS concentrations of 20 mg/L.

I) Provide one (1) dechlorination system.

J) Replace (as needed) two (2) 230 volt backwash pumps.

H) Test and repair wiring, circuits, starters and relays necessary to return filter control system to specifications.

The contract price for services outlined in this contract is \$94,860.00 (Ninety four thousand eight hundred sixty dollars, no cents).

"The Bank" shall pay "WSI" according to the following payment schedule;

25% of the total contract price \$23,715.00 (Twenty three thousand seven hundred fifteen dollars, no cents) shall be due at the time this agreement is signed by The Bank.

25% of the total contract price \$23,715.00 (Twenty three thousand seven hundred fifteen dollars, no cents) shall be due when WSI starts work to sand blast the tanks.

20% of the total contract price \$18,972.00 (Eighteen thousand nine hundred seventy two dollars, no cents) shall be due upon completion of the painting of the tanks and the start of the rehabilitation of the influent and aeration systems.

20% of the total contract price \$18,972.00 (Eighteen thousand nine hundred seventy two dollars, no cents) shall be due upon completion of the influent, aeration and clarifier and the start of the nitrification tower.

10% of the total contract price \$9,486.00 (Nine thousand four hundred eighty six dollars, no cents) shall be due upon completion of the total work specified by the contract.

United Bank
14226 Albermarle Point Place
Suite 100
Chantilly, VA 20151

Water Services, Inc.
14-E Irongate Drive
Waldorf, MD 20602

[Signature]
Name

[Signature]
Edward Crooks

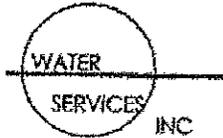
SWP Facilities Div.
Title

OWNER
Title

5/14/12
Date

5/10/12
Date

SCOPE OF WORK FOR WATER TANK ATTACHED BEHIND



Copy

14 E Irongate Drive
Waldorf, Maryland 20602

301.645.2798...phone
301.705.5734...fax

May 9, 2012

**CONTRACT FOR SERVICES
BY AND BETWEEN WATER SERVICES, INC. AND UNITED BANK**

Water Services, Inc. located at 14-E Irongate Drive, Waldorf, MD 20602 (herein after known as "WSI") and United Bank located at 14226 Albermarle Point Place, Suite 100, Chantilly, VA 20151 (herein after known as "The Bank") through their duly appointed representatives agree to the terms and conditions specified in this contract.

"WSI" and "The Bank" specify that the representative signing the contract has the authority to enter into binding agreements on behalf of "WSI" and "The Bank".

"WSI" and "The Bank" specify that all current or future owners, assignees, stockholders, and board of directors shall be bound by the terms and conditions specified and agreed to in this contract.

"WSI" and "The Bank" specify that bankruptcy shall not be grounds to nullify the terms and obligations specified in this contract.

Failure to abide by the terms of this contract by either signatory, shall result in default by that signatory. The defaulting signatory shall be responsible for all court costs, legal fees, and all reasonable costs incurred to enforce the terms of this contract.

"WSI" shall maintain workmans comp insurance and liability insurance providing "The Bank" with a copy upon request;

"WSI" shall provide all materials and labor necessary to perform the work specified in the contract;

"WSI" shall follow safe work practices as specified by OSHA and MOSH;

"WSI" shall hold harmless and indemnify "The Bank" against any claims resulting from the work performed by WSI in the execution of this contract.

"WSI" shall perform the services listed herein. Required service shall be limited to the scope of work specified in this contract.

"WSI" shall;

I Water Meter

- A) Install one (1) 1 1/2" direct read water meter at the water plant well house.

II Water Tank

- A) Sand blast exterior surface of the existing water tank to bare metal.
- B) Paint exterior surface of the existing water tank with two part epoxy paint specified as suitable by the manufacturer (Dura-Plate 235 multipurpose epoxy).

Cost: \$9,225.00 (Nine thousand two hundred twenty five dollars, no cents).

United Bank
14226 Albermarle Point Place
Suite 100
Chantilly, VA 20151

Water Services, Inc.
14-E Irongate Drive
Waldorf, MD 20602

Columbia
Name

Edward Crooks
Edward Crooks

SVP - Facilities Director
Title

OWNER
Title

5/14/12
Date

5-10-12
Date

SCOPE OF WORK FOR A/C REPLACEMENT ATTACHED BEHIND

PROJECT AGREEMENT

June 7, 2012

(B1/B2/B3/B4-A/C Replacements)

By and Between:

American Mechanical Services
13300 Mid Atlantic Blvd.
Laurel, Maryland 20708

and

Uniwest Commercial Realty
8191 Strawberry Lane, Suite 3
Falls Church, VA 22042

(The Company)

(The Client)

American Mechanical Services will provide Project services at the 13400 Edgemoade Road, Upper Marlboro, Maryland.

The Project will provide materials and labor to accomplish the following scope of work:

- ✦ Recover refrigerant from (8) A/C units for recycling and demo furnaces and coils to be removed from site.
- ✦ (8) Carrier 3.5 ton R-410A refrigerant condenser and matching, 13 SEER coils, line sets of proper sized, fused outside electrical service disconnects.
- ✦ A/C model: 24ABB324W003, 13 SEER furnace Model: 08LAAB036098 85% efficient
- ✦ (8) Sheet metal duct transitions for supply and returns filter racks with new filters.
- ✦ Startup and preform heating and cooling efficiency tests.
- ✦ Five year parts only compressor warranty from Manufacturer, one year on install related items, 60 days on service calls.
- ✦ All permits included.

The Project does not include the following, which are specifically excluded:

- ✦ Overtime.

The Project will be provided for the sum of Sixty Thousand, Three Hundred, Eighty Five Dollars 00/100 (\$60,385.00)

If parts or equipment prove defective, The Company will extend to The Client the benefits of any warranty The Company has received from the manufacturer. Removal and reinstallation of any equipment or materials repaired or replaced under a manufacturer's warranty will be at The Client's expense and at the rates then in effect.

This proposal is in effect for a period of fifteen (15) days after the above proposal date, and can be extended beyond this period only at the option of The Company.

This work shall be provided in accordance with the terms and conditions contained herein including those on the reverse side. This Agreement shall constitute the entire agreement between us.

For The Company:
American Mechanical Services

Approved For The Client:
Uniwest Commercial Realty

By: _____
 Brandon McBarron
Title: _____
 Field Supervisor
Date: _____
 June 7, 2012

By: _____
Title: _____
Date: _____

Exhibit 5



Government of the District of Columbia

HUMAN CARE AGREEMENT										PAGE	OF	PAGES		
1. CONTRACT NUMBER DCJZ-2014-H-0007					2. REQUISITION/PURCHASE REQUEST NO.			3. EFFECTIVE DATE 1 30						
4. ISSUED BY Office of Contracting and Procurement 441 4 th Street, NW, Suite 700S Washington, DC 20001					5. ADMINISTERED BY (If other than Item 5): Department of Youth Rehabilitation Services 8300 Riverton Court Laurel, Maryland 20724									
6. NAMES AND ADDRESS OF PROVIDER/PROVIDER(No. Street, county, state and ZIP Code) Seasons Residential Treatment Program, LLC. 13400 Edgemoade Road. Upper Marlboro, Maryland 20772 Telephone: 404-433-5205 Fax: E-Mail:														
7. PROVIDER/PROVIDERS SHALL SUBMIT ALL INVOICES TO: Department of Youth Rehabilitation Services Office of the Chief Financial Officer 8300 Riverton Court Laurel, MD 20724						8. DISTRICT SHALL SEND ALL PAYMENTS TO: Seasons Residential Treatment Program, LLC. 13400 Edgemoade Road. Upper Marlboro, Maryland 20772								
9. DESCRIPTION OF HUMAN CARE SERVICE AND RATE COST														
ITEMLINE NO.	NIGP CODE	BRIEF DESCRIPTION OF HUMAN CARE SERVICE					QUANTITY OF SERVICE REQUIRED	TOTAL SERVICE UNITS	SERVICE RATE	TOTAL AMOUNT				
0001	952-95	Short Term Placement Services (Staff Secured)							See					
0002	952-95	Short Term Placement Services (Hardware Secured)							Schedule B					
0003	952-95	Educational Services												
									Total	\$				
									Total From Any Continuation Pages	\$				
									GRAND TOTAL	\$				
10. APPROPRIATION DATA AND FINANCIAL CERTIFICATION														
LINW	AGY	YEAR	INDEX	PCA	OBJ	AOBJ	GRANT/PH	PROJ/PH	AG1	AG2	AG3	PERCENT	FUND SOURCE	AMOUNT
A. SOAR SYSTEM OBLIGATION CODE:		B. Name of Financial Officer (Typed): Title:					C. Signature:				D. Date:			
11. PERIOD OF HUMAN CARE AGREEMENT														
Starting Date:						Ending Date:								
HUMAN CARE AGREEMENT SIGNATURES														
Pursuant to the authority provided in D.C. Law 13-155, this HUMAN CARE AGREEMENT is being entered into between the Provider/Providers specified in Item No. 7 and Item No. 12 of page 1 of this document. The Provider/Providers is required to sign this document and return 3 original and signed copies to the Contracting Officer of the Issuing Office stated in Item No. 4 of page 1 of this document. The Provider further agrees to furnish and deliver all items or perform all the services set forth or otherwise identified within this Human Care Agreement and on any continuation sheets or appendices for the consideration stated above. The rights and obligations of the parties to this Human Care Agreement shall be subject to and governed by the following documents: (a) this Human Care Agreement, (b) the STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA GOVERNMENT SUPPLY AND SERVICES CONTRACTS, dated October 1, 1999; (c) Any other provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. This Human Care Agreement between the signatories to this document consummates the final agreement of the parties.														
12. FOR THE PROVIDER/ CONTRACTOR						13. FOR THE DISTRICT OF COLUMBIA								
A. Name and Title of Signer (Type or print) Name: TEARASIS JOHNSON Title: OWNER						A. Name of Contracting Officer (Type or print) Joseph Stewart.								
B. Signature of the PROVIDER/CONTRACTOR: 						C. DATE 3/11/14		B. Signature of CONTRACTING OFFICER: 				C. DATE 4/18/14		

THE SCOPE OF HUMAN CARE SERVICES

SECTION 1 – HUMAN CARE SERVICES AND SERVICE RATES

- 1.1 The Government of the District of Columbia, Office of Contracting and Procurement, Department of Youth and Rehabilitation Services, hereafter referred to as the “District,” is Contracting through this Human Care Agreement with Seasons Residential Treatment Program LLC, hereafter referred to as the “Provider,” for the purchase of human care services pursuant to the Human Care Agreement Amendment Act of 2000, Section 406 of the Procurement Practices Reform Act of 2010, effective April 8, 2011 (D.C. Law 18-371; D.C. Official Code § 2-354.06).
- 1.2 The District is not committed to purchase under this Human Care Agreement any quantity of a particular service covered under this Agreement. The District is obligated only to the extent that authorized purchases are made pursuant to the human care agreement.
- 1.3 Delivery or performance shall be made only as authorized by Task Orders issued in accordance with the Ordering Clause. The Provider shall furnish to the District Government, when and if ordered, the services specified in the Price Schedule
- 1.4 There is no limit on the number of Task Orders that may be issued. The District Government may issue Task Orders requiring delivery to multiple destinations or performance at multiple locations
- 1.5 This is a Human Care Agreement based on fixed unit rates. The provider shall deliver services in accordance with Section 4.

SECTION 2 PRICE SCHEDULE / FIXED UNIT RATE

- 2.1 The District is not committed to purchase under this Human Care Agreement any quantity of a particular service covered under this Agreement. The District is obligated only to the extent that authorized purchases are made pursuant to the human care agreement. DYRS is not responsible for the educational costs incurred for special education services for those youth who have a valid IEP. The Provider shall be responsible for submitting invoices for special education services to the Office of the Superintendent of Special Education (OSSE) in the District of Columbia.

2.1.1 Base Year

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
0001	Short Term Placement Services in the Staff secured facility as described in Sections 4.1	Client/Per Day	\$ <u>365.00</u>
0002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>380.00</u>

Awaiting Placement
 DCJZ-2014-H-0007

0003	Educational Services, as described in Section 4.5	Client/Per Day	\$ <u>100.00</u>
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2.1.2 Option Year One

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
1001	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>383.00</u>
1002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>399.00</u>
1003	Educational Services, as described in Section 4.5	Client/Per Day	\$ <u>100.00</u>

2.1.3 Option Year Two

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
2001	Short Term Awaiting Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>402.00</u>
2002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>419.00</u>
2003	Educational Services, as described in Section 4.5	Client/Per Day	\$ <u>100.00</u>

2.1.4 Option Year Three

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
3001	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>423.000</u>
3002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>440.00</u>
3003	Educational Services, as described in Section 4.5	Client/Per Day	\$ <u>100.00</u>

2.1.5 Option Year Four

Agreement Line Item Number	Services Description	Service Unit	Fixed Unit Rate
4001	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>444.00</u>
4002	Short Term Placement Services in the Hardware secured facility as described in Sections 4.1	Client/Per Day	\$ <u>462.00</u>
4003	Educational Services, as described in Section 4.5	Client/Per Day	\$ <u>100.00</u>

SECTION 3 – SCOPE OF HUMAN CARE SERVICES

3.1 The Government of the District of Columbia, on behalf of the Department of Youth Rehabilitation Services, is seeking providers that shall operate staff secured and/or hardware-secured, Short Term Placement, 24-hours, maximum 25-bed facilities to provide services to the DYRS population as specified in Section 4.

3.1.1 Applicable Documents

Item No.	Document Type	Title	Date
1	Court Document	Jerry M., et al Plaintiffs v. District of Columbia, et al., Defendants Civil No. 1519-85 (IFP) – Synopsis	7-10-86

		<p>Superior Court of the District of Columbia</p> <p>Available at: Bureau of Courts and Community Services Department of Youth Rehabilitation Services 450 H Street, NW Washington, D.C. Telephone: 202-724-5071</p>	
2		<p>Federal Individuals with Disabilities Education Act, 20 U.S.C.A. § 1400 <u>et seq</u>, Subchapters I and II available at http://fedlaw.gsa.gov or http://www.law.cornell.edu/uscode/</p>	1990
3	<p>Public Law 101-336, July 26, 1990</p>	<p>Americans with Disabilities Act 42 USCA § 12101-102; 12131-134. available at http://fedlaw.gsa.gov or http://www.law.cornell.edu/uscode/</p>	1990
4	<p>D.C. Law Concerning Proceedings Regarding Delinquency, Neglect or Need of Supervision</p>	<p>D.C. Official Code, Section 16-2301-2372 available at http://dccode.westgroup.com</p>	
5		<p>District Personnel Manual Mandatory Employee Drug & Alcohol, Chapter 39 of the District Personnel Regulations</p>	
6	<p>DYRS Document (Policy & Procedures)</p>	<p>Unusual Incident & After Hours Emergencies Protocol</p> <p>Available at: Division of Courts and Community Services Department of Youth Rehabilitation Services 450 H Street, NW Washington, DC 20001 Telephone: 202-724-5071</p>	
7		<p>Education for All Handicapped Children Act 1975 (P.L. 94-142);</p>	

8		DYRS Establishment Act and specifically, D.C. Code § 2-1515.04,	
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3.2 Definitions

- 3.2.1 **Abscondence:** The youth is absent from an approved placement.
- 3.2.2 **Bio-Psychosocial Assessment:** An assessment that considers biological, psychological, and social factors in evaluating a youth's mental health, social status, and functional capacity.
- 3.2.3 **Community Placement Agreement:** – Document detailing requirements and conditions for the youth that govern his or her community placement.
- 3.2.4 **Education support/advocacy:** Services designed to increase the educational skills of youth. These may include individualized approaches as well as use of non-traditional methods and materials, for example, computers, mentors, or tutors.
- 3.2.5 **IDEA:** Individuals with Disabilities Education Act is a law ensuring services to children with disabilities.
- 3.2.6 **Individual Education Program (IEP):** Program designed to meet the unique educational needs of a child who may have a disability.
- 3.2.7 **Individualized Service Plan (ISP):** Also referred to as Individualized Development Plan (IDP). This is a document that specifically identifies the goals, objectives, strategies, responsible parties and resources to address the assessed strengths and needs of a committed youth and the family. The DYRS case manager designs the plan to ensure that habilitative and rehabilitative services are correlated to the Positive Youth Development Model (PYD) principles which is a comprehensive way of thinking about the development of adolescents and the factors that facilitate their successful transition from adolescence to adulthood. The plan is developed and periodically updated in conjunction with the DYRS case manager, youth, youth's family and designated service providers
- 3.2.8 **Individual Treatment Plan (ITP):** A document developed by a planning team comprised of Provider clinical staff, youth, youth's family and DYRS case manager. The ITP serves as the single document that integrates all support a youth may receive irrespective of where the youth resides. The ITP presents the measurable goals and objectives as it relates to youth's strengths, needs, diagnosis, and desired outcomes. The ITP also addresses the provision of safe, secure, and dependable support that is necessary for the youth's well-being, independence and social inclusion.

- 3.2.9** **Qualified Personnel:** Persons holding official credentials, accreditation registration, certification, or licenses issued by their jurisdiction and, for the purposes of providing services to youth. The term shall include administrators, therapists, professional nurses, physicians, psychologists and professional counselors, and social workers. Persons providing direct care to DYRS youth should be suitable for employment pursuant to 29 DCMR 6228.
- 3.2.10** **MAYSI-2:** The MAYSI-2 is a standardized, 52-item, true-false method for screening every youth of ages 12-17 entering the juvenile justice system, in order to identify potential mental health problems in need of immediate attention
- 3.2.11** **Trauma-Based Behavioral Health Care:** An evidence-based treatment approach designed to help youth overcome trauma-related difficulties by reducing negative emotional and behavioral responses.

3.3 **BACKGROUND**

- 3.3.1** The Department of Youth Rehabilitation Services (DYRS) serves youth up to age 21 who have been committed to its care and custody by the D.C. Superior Court Family Division. DYRS' mission is to improve public safety and give court- involved youth the opportunity to become more productive citizens by building on the strengths of the youth and their families in the least restrictive, most homelike environment. In partnership with the community, this balanced approach to juvenile justice promotes the rehabilitation of delinquent youth toward reforming their behavior in the context of increased accountability, expanded personal competencies, positive youth development and enhanced community restoration. Pursuant to the DYRS Establishment Act and specifically, D.C. Code § 2-1515.04, DYRS is responsible for establishing through contracts, Provider agreements, human care agreements, grants, memoranda of agreement or understanding, or other binding agreements a system of secure and community-based facilities and rehabilitative services with governmental bodies, public and private agencies, institutions, and organizations, for youth that will provide intervention, individualized assessments, continuum of services, safety, and security.
- 3.3.2** Youth committed to DYRS following a court disposition hearing or youth who are in need of an alternate placement to facilitate treatment may need to be placed in a short term staff secure or hardware secure facility while awaiting placement in a long-term rehabilitative treatment program. Currently, male youth in need of a hardware-secure facility while awaiting placement are housed at the DYRS New Beginnings Youth Development Center and female youth are housed at the DYRS Youth Services Center (YSC). The Provider selected will provide short Term Awaiting Placement services at a staff secured and /or hardware-secured facility for up to 25 youth.
- 3.3.3** Certain requirements of this solicitation are extremely important to DYRS in carrying out its responsibilities for this recurring need. Such components include a 24-hour staff secure/hardware secure facility that can provide diagnostic and assessment, educational programming, and rehabilitative treatment as mandated by law, DYRS directives, court orders and consent decrees.
- A. DYRS is subject to the Jerry M. Consent Decree, a comprehensive mandate which addresses, in part, programmatic and operational objectives. The decree and court orders focus on reform

initiatives associated with the facilities, services and delivery of services to the youth placed in the custody and care of DYRS.

- B. DYRS provides enriched, culturally sensitive services, including recreational, rehabilitative, educational, mental health, medical, recreational, aftercare supervision, residential placements, independent living and mentoring/monitoring support in a nurturing and structured environment to the youth in its custody.

SECTION 4 REQUIREMENTS

- 4.1** The Provider shall operate staff secured /or a hardware-secured, short-term, 24-hour, facility for up to 25 youth to provide services to the DYRS awaiting placement population. The Provider facility shall accommodate youth between the ages of 12 and 21. This facility will provide a safe, highly-structured, stable and secure environment for youth who:
- a. Have been committed to DYRS following disposition by the D.C. Superior Court and are awaiting placement at a long-term facility; or
 - b. Are in noncompliance with the terms of their Community Placement Agreement and will require immediate placement at the proposed 24-hour facility for a prompt risk reassessment, intervention, data tracking and sanctions under the Graduated Responses Matrix for noncompliance.
- 4.2** The duration of placement for each youth will be assessed on a case-by-case basis, but should generally not exceed 28 days.
- 4.3** **Basic Program Expectations and Services**
- 4.3.1** The Provider shall provide the following services to youth:
- 1. Intake and diagnostic screening
 - 2. Onsite medical/dental care
 - 3. Trauma-based behavioral health care
 - 4. Individual and group counseling
 - 5. Substance abuse counseling
 - 6. Drug and alcohol testing
 - 7. Onsite education (including special education services)
 - 8. Structured recreation
 - 9. Life skills training
 - 10. Family visits/engagement
 - 11. Transition services
 - a. Discharge summaries/report writing
 - b. Information-sharing with long term placement providers and DYRS
 - c. Secure transportation
 - i. to and from judicial proceedings (court)
 - ii. to and from long-term placement
 - iii. case status review meeting, if applicable
 - iv. Medical and other services rendered in the community.

12. Behavioral health management/incentive system
13. Nutrition/food services
14. Case planning services
 - a. Youth and Family Team meetings
 - b. Community Status Review hearings
 - c. Private meeting areas for attorney visits
 - d. Video conferencing
 - e. Individual Development Plans (IDP)
 - f. Individual Education Program (IEP)
 - g. Individual Treatment Plan (ITP)

4.4 **Intake and Diagnostic Screening**

- 4.4.1 The Provider shall accept DYRS youth 24 hours a day, seven days a week and shall provide risk assessments, medical screening, and service planning within 72 hours of placement. If a youth, depending upon placement status and initial assessment, will remain at the facility for more than 48 hours, the Provider shall provide additional assessments as determined in conjunction with the DYRS case manager assigned to the youth.
- 4.4.2 The Provider shall have the capacity to administer the MAYSI-2 within 48 hours of admission.
- 4.4.3 The Provider shall conduct any risk assessment tool designated by DYRS.
- 4.4.4 For youth who remain at the facility more than seven days, the Provider shall have the capability to provide a Bio-Psychosocial Assessment to be completed by a clinical social worker.

4.5 **Educational Services**

- 4.5.1 If located within the District of Columbia, the Provider shall provide educational services Monday through Friday through a DC Public Schools (DCPS) certified education program. Staff secured facilities located within the District of Columbia may allow residents to attend school within the community. If located outside of the District of Columbia, the Provider shall provide educational services Monday through Friday through a program certified by the jurisdiction in which they are located. Hardware secure facilities and facilities outside the District of Columbia must provide educational services on the grounds of the facility.

Teachers will initially test all youth in mathematics and reading within 72 hours of placement to assess their level of ability. In addition, teachers will assess the youth's education and social history to determine the appropriate individualized daily curriculum for each youth.

- 4.5.2 The Provider shall ensure that the teacher coordinates with the youth's current school program to coordinate the completion of assignments from that program, or shall develop an acceptable curriculum if the youth is not currently enrolled in a school program. In the event the DYRS youth is being released to the community, the provider shall coordinate with DC Public schools to transition the youth back to his prior school placement or to an alternative school placement within the DC Public School system.

- 4.5.3 The Provider shall help to coordinate youth's education services with the youth's long term placement and ensure the transfer of information concerning the youth's educational services.
- 4.5.4 The Provider shall comply with the federal IDEA requirements and ensure that all youth with special education needs receive high quality and appropriate educational services.
- 4.6.1 **Trained Staff and Education Criteria**
- 4.6.2 The Contractor's staff shall consist of professional, paraprofessional and support personnel.
- 4.6.3 Juvenile justice professionals must be highly skilled and experienced with the principles, goals, and the latest advancements of juvenile rehabilitation and treatment provision, including the principles of Positive Youth Development. Direct care staff should preferably have 60 hours of college credit.
- 4.6.4 The Provider shall have a staffing pattern that provides on-site trained staff for twenty-four (24) hour coverage, seven (7) days a week (including holidays) based on the number of youth placed at the facility, to provide supervision and programming. The Contractor's professional and administrative staff shall consist of, at a minimum:
1. Center Administrator/Director with a Master's level degree;
 2. Staff Assistant or equivalent;
 3. Case Manager/Treatment Specialist with a bachelor's degree or equivalent to provide services to the youth and coordinate services with DYRS case managers;
 4. Certified Addictions Counselor
 5. Licensed Social Worker and or Licensed Professional Counselor with a District License
 6. Direct Care Staff such as youth counselors or youth development workers to provide supervision and behavior management treatment to meet the treatment needs of the youth and to ensure the safety and security of the facility, youth, and the security of the public.
 7. Nurse
- 4.6.5 The Provider shall have written policies that provide details describing program management, admissions, living and environment, case management, behavior management, program security, program safety, and conditional release. **The Contractor's employee will be trained annually in all agency policies and procedures.** These policies shall include at a minimum:
1. Orientation;
 2. Staff training & development;
 3. Non-discrimination, in accordance with the D.C. Human Rights Act of 1977, as amended, D.C. Official Code § 2-1401.01 *et seq*;
 4. Sexual harassment, in accordance with D.C. Mayor's Order 2004-171;
 5. Employee performance evaluation;
 6. Hours of work;
 7. Disciplinary procedures;
 8. Terminations;
 9. Use of force;
 10. Safe crisis management
 11. Reporting unusual incidents;

12. Procedures for Reporting allegations of abuse, harm and risks to youth,
13. Employee conduct;
14. Search and seizure of weapons & illegal contraband;
15. Mandatory employee drug and alcohol testing;
16. Confidentiality of youth information;
17. Youth supervision and movement;
18. Suicide prevention;
19. Use of physical restraint;
20. Youth rights & responsibilities;
21. Grievance Process
22. Youth clothing;
23. Emergency preparedness plan (inclusive of sufficient food, water and equipment),
24. Housekeeping and inspection;
25. Youth phone access and visitation;
26. Secure youth transportation;
27. Abscondence; and
28. Positive Youth Development

- 4.6.6** The Provider shall provide sufficient qualified staff to support the treatment and rehabilitative needs of each youth. Staff shall have the requisite qualifications to provide services to the populations. Staff members responsible for performing professional services, including psychological, psychiatric, medical, social work, nursing, dental and education shall have a professional degree and appropriate license in his or her respective fields from an accredited college or university and current license if required by law.
- 4.6.7** The Provider shall ensure that staff is competent and sensitive in providing treatment to persons of diverse cultural backgrounds, as well as responsive to the needs of minority individuals.
- 4.6.8** The Provider shall maintain a complete, confidential individual personnel file for each staff person, contractor or volunteer containing the signed contract, employment or volunteer application, personal and professional references, applicable licenses, credentials and/or certificates, records of required medical examinations, personnel actions including time records, documentation of all training received, notation of any allegations of professional or other misconduct and actions with respect to the allegations and date and reason if terminated from employment or from providing volunteer services, which shall be accessible to the DYRS Contract Administrator (CA).
- 4.6.9** The Provider shall provide job descriptions for all staff positions to the DYRS CA within thirty (30) days from date of award. Each job description shall accurately describe duties for the position and include, at a minimum: job title, responsibility of the position and the required minimum education and experience. The Provider may use part time personnel in any employment category except for the director or equivalent position. A part-time employee is any employee employed for less than 40 hours per week. Full-time employment is defined as forty hours (40) per week.

- 4.6.10** The Provider shall provide orientation and training for all staff members with respect to administrative procedures, patient rights, confidentiality of youth records, including treatment records, reporting allegations of abuse and other risks to youth, grievance procedures and other relevant policies, procedures and protocols of DYRS and the Contractor.
- 4.6.11** The Provider shall maintain a current organizational chart displaying organizational relationships and responsibility lines of administrative oversight and supervision.
- 4.6.12** All personnel materials, including the individual personnel file, for each employee providing services pursuant to this Statement of Work shall be made available to the DYRS CA for review upon request.
- 4.6.13** The Provider shall ensure that direct services staff persons maintain certifications annually in Cardio-Pulmonary Resuscitation (CPR) and First Aid.
- 4.6.14** The Provider shall adhere to the following staff security requirements:
1. In accordance with DC Official Code § 4-1501.01 et seq., the Provider shall conduct routine pre-employment and annually criminal record background checks of the Provider's applicable staff, volunteer, contractor and future staff that will provide services pursuant to this Statement of Work. The Provider shall not employ any staff in the fulfillment of the work pursuant to this Statement of Work unless said person provides the results of a background check, to include FBI, a National Criminal Information Center Report and annual Child Protective Services Report (abuse and neglect). Staff shall not have any convictions of child abuse, child neglect, spousal abuse, a crime against children, including child pornography or a crime involving violence, including but not limited to, rape, sexual assault, homicide and assault for any disqualifying offenses as enumerated in 29 DCMR 6228.
 2. After award of the contract, the Provider shall furnish copies of the certified criminal history records of applicable Provider staff, contractor or volunteer to the Contract Administrator upon request. Any conviction or arrest of the Contractor's employees, contractor or volunteer will be reported to the DYRS Contract Administrator within five (5) days of notification from NCIC or FBI, for further review and final determination of eligibility for employment by the D.C. Department of Human Resources (DCHR).
- 4.6.15** The Contractor's employees, contractors and volunteers shall have a pre-employment drug test and be subject to ongoing random mandatory drug and alcohol testing in accordance with District of Columbia's Mandatory Employee Drug and Alcohol Testing (MEDAT) regulations.
- 4.6.16** The Provider shall always be responsible for the effective supervision and treatment of DYRS youth and the orderly operation of the facility and shall notify DYRS of any unforeseen circumstance, which may affect the safety, security, or orderly operation of the facility.
- 4.7** **CONTRACTOR'S FACILITY**
- 4.7.1** The orientation and assessment facility shall include, but not be limited to, separate sleeping quarters for each youth, dining area and space for recreation.

- 4.7.2 The Provider shall provide in the facility internet accessible computer, telephone, fax, scanner, e-mail, and TTY and TDY service. The Contractor's facility shall be in accordance with the following:
1. The Contractor's facility shall have a license in good standing and in compliance with all local and federal regulations.
 2. The Provider shall maintain an emergency plan approved by local fire officials that clearly documents emergency preparedness, which includes information about the emergency site arrangements. The Contractor's emergency preparedness plan shall be available for review upon the request of the Contract Administrator and the designated program monitor. The emergency plan shall be reviewed annually, updated as necessary, and redistributed as changes occur.
 3. The Provider shall provide, at no additional cost to the District, supplies and services routinely needed for maintenance and operation of the home, such as, but not limited to, security, janitorial services, trash pick-up, laundry or linens.
 4. The District reserves the right to inspect the facility prior to placement of youth. The District will conduct periodic, scheduled and unscheduled site visits for the purpose of directly observing the provision of services and discussing performance relative to the terms and conditions of a task order.
 5. The Provider shall ensure that the facility meets all licensing, registration and occupancy requirements, building safety, fire, health and sanitation codes and all other required certifications as prescribed by the governing jurisdiction and maintain current all required permits and licenses.

4.8 FOOD SERVICES

- 4.8.1 The Provider shall provide three (3) meals and a snack a day for youth in accordance with a menu approved by a licensed nutritionist listing for seven (7) days a week.
- 4.8.2 The Provider shall make arrangements for special diets as required by a youth's physician or dentist.
- 4.8.3 The Provider shall comply with all regulations pertaining to handling of food in accordance with the regulations set forth by DCRA or state-equivalent and the USDA Model Food Code.
- 4.8.4 The Provider shall make their food service facility available to DYRS for inspections.

4.9 POLICY AND PROCEDURE MANUAL

The Provider shall conform to DYRS policies and procedures, Program Statements and all DYRS and Court Orders as cited herein, which will be made part of any contract. A copy of these documents can be requested in writing from:

Department of Youth Rehabilitation Services
Management Support Services
8400 River Road
Laurel, MD 20724

4.10 OTHER PROVIDER REQUIREMENTS

1. Adhere to licensing regulations and state requirements in accordance with all existing federal and District of Columbia or state-equivalent laws, rules and regulations.
2. Provide the DYRS Contract Administrator immediate notification of any restriction, suspension or other disciplinary actions taken by your state licensing or regulatory agency.
3. Commit to a philosophy of unconditional care, by agreeing not to eject a youth that have been accepted but rather renegotiate an individual placement with the agency on a particularly difficult referral.

4.11 ADMINISTRATIVE OPERATIONS

The Provider shall, at a minimum, provide or maintain the following administrative operations to support the delivery of extended family or therapeutic services for youth:

1. Provide services 24 hours per day seven days per week. The Provider shall maintain an administrative office, which shall operate at a minimum from 9:00 a.m. to 5:00 p.m., Monday through Friday, except on federal holidays.
2. Report all unusual or critical incidents, including abscondence, involving youth referred by the District in accordance with the policies and procedure as approved by DYRS.
3. **Reports due to DYRS must be submitted to the DYRS case manager and to dyrs.providerreport@dc.gov**

4.12 JUVENILE SERVICES

The Providers shall maintain comprehensive case files for each youth including historical, background, and other relevant information received from DYRS case managers. Case files shall be maintained in a manner that is both organized and representative of the youth's progress based on the youth's prescribed ISP and updates to the ISP. Case files shall include daily progress notes for individual youth. The Provider shall also provide the DYRS case manager with a work plan that details the intensity and frequency of services described in the ISP, within 15 days of receiving the ISP. The work plan shall address, but not be limited to, the following:

1. Supervision and treatment by providing activities designed to provide external constraints for the youth's behavior, monitor the behavior, and strengthen the adherence and acceptance of rules.
2. Provide regularly scheduled recreation/leisure/cultural activities designed to engage, stimulate and expose youth to vocational, artistic and consciousness raising pursuits.
3. Coordinate with the DYRS case manager for clinical services necessary to meet and support the treatment objectives and strategies described in the ISP, including, but not limited to, individual and group counseling that focuses on day-to-day adjustment issues. This may also include formal psychotherapeutic or behavior modification techniques.

4.13 REPORTS

4.13.1 The Provider shall provide the Contract Administrator with quarterly report data that supports DYRS' quality assurance plan used to assess the effectiveness of the Contractor's services. The Quarterly report shall, at a minimum, include the following information:

1. Names and number of youth admitted to the program.
2. Names and number of youth receiving services.
3. Number and content of training for staff (includes list of participants and participant evaluations).
4. Name and position of staff working with DYRS youth.

4.13.2 The Provider shall prepare and submit individual monthly progress reports to the assigned DYRS case manager. The monthly progress report shall, at a minimum, document the youth's progress in each identified area of service as follows:

1. Life skills;
2. Recreation and leisure activities;
3. Academic performance;
4. Individual therapy;
5. Group therapy;
6. Addiction support;
7. Health/medical updates;
8. Unusual incidents;
9. Abscondence reports; and
10. Updated service strategies.
11. Psychiatric/psychological evaluations
12. Medication assessments

C.14 ELIGIBILITY

Eligibility for services under the agreement with DYRS shall be determined and re-determined by the District, as applicable, in accordance with prescribed procedures. The Provider shall be subject to a written determination that it is qualified to provide the services and shall continue the same level of qualifications, subject to a review by the District, according to the criteria delineated in 27 DCMR, Chapter 19, Section 1905.6, as amended.

SECTION 5 DELIVERABLES for Base Year and Option Years 1 through 4
(All Deliverables shall be delivered to the CA specified in Section 17)

5.1 Deliverable for Base Year and Option Years 1 through 4 (All Deliverable shall be delivered to the Contract Administrator specified in Section 16. a)

Contract Line Item Number (CLIN)	Deliverable	Method of Delivery	Due Date
0001 - 0002 1001 - 1002 2001 - 2002 3001 - 3002 4001 - 4002	Initial ITP	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name (Placement) - Youth's Name - Facility Name - Date Completed - Date submitted	The initial ITP shall be completed and submitted within 15 days of placement to the DYRS case manager and dyrs.providerreport@dc.gov
0001 - 0002 1001 - 1002 2001 - 2002 3001 - 3002 4001 - 4002	Updated Treatment Plans and/or Monthly Progress Reports	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted - Projected Release Date	Updated Treatment Plans and/or Monthly Progress Reports are due the 10 th day of each month to the DYRS case manager and dyrs.providerreport@dc.gov
0001 - 0002 1001 - 1002 2001 - 2002 3001 - 3002 4001 - 4002	Transitional Plan	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted - Scheduled Release Date	Transition Planning Report is due 90 days before the projected discharge date and should accompany the monthly progress report to the DYRS Case Manager, and dyrs.providerreport@dc.gov
0001 - 0002 1001 - 1002 2001 - 2002 3001 - 3002 4001 - 4002	Discharge Package	1 electronic copy and/or 1 soft copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted - Scheduled Release Date	The Discharge package shall be submitted 60 days before the scheduled discharge date to the DYRS Case Manager and dyrs.providerreport@dc.gov

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0001 - 0002 1001 - 1002 2001 - 2002 3001 - 3002 4001 - 4002	Emergency Plans	1 electronic copy to clearly labeled with the following: -Deliverable Name -Facility Name -Date of Revision	The Emergency Plan with alternative placement sites is to be submitted to the CA 10 business days after award of a Human Care Agreement to the CA and dys.providerreport@dc.gov
0001 - 0002 1001 - 1002 2001 - 2002 3001 - 3002 4001 - 4002	DYRS Unusual Incident Report	1 electronic copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted	All Unusual Incident Reports shall be submitted via email or telephone by the end of the shift in which the incident occurred and followed up with a written report to the CA and DYRS Case Manager within 24 hours and dys.providerreport@dc.gov
0001 - 0002 1001 - 1002 2001 - 2002 3001 - 3002 4001 - 4002	DYRS Absconder Report	1 electronic copy clearly labeled with the following: - Deliverable Name - Youth's Name - Facility Name - Date Completed - Date Submitted	All Absconder Reports shall be submitted to the CA via email by the end of the shift in which the incident occurred with a copy forwarded to the DYRS case manager and Quality Assurance Unit and dys.providerreport@dc.gov

Section 7 District Responsibilities

7.1 The Department of Youth Rehabilitation Services will provide the following: a) written requests for care indicating youth identified as needing psychiatric services b) reasonably quiet, confidential space to see youth; c) access to medical charts; d) Provide training courses in "Safe Crisis Management" and "Suicide Prevention" and CPR; e) develop and implement quality assurance tools to evaluate the provider's performance on responsibilities indicated above; and f) DYRS shall makes payments to the provider on a monthly basis for the services provided during the previous month as invoiced.

Section 8 Monitoring

8.1 a) The Department of Youth Rehabilitation Services shall monitor the quality of services provided; and b) monitoring shall include, but is not limited to, review of documentation in medical charts, monitoring of medications prescribed by the Pharmacy and Therapeutic Committee, and review of labs ordered based on standard baseline labs to be completed for psychotropic medication monitoring.

Section 9 Compliance With Service Rates

9.1 All human care services shall be provided, and the District shall only pay, in accordance with the service rates shown in Section 2, Human Care Services and Service Rates. If any overpayment occurs, the provider shall repay the District the full amount of the overpayment. The Provider shall provide no human care unless the District makes an official referral and issues a task order to the Provider.

Section 10 Method of Delivery of Services

- 10.1 a) Youth are to be seen face-to-face based on request for care received from the youth, behavioral health staff or medical staff; and
- 10.2 b) Psychiatric or forensic evaluations are completed based on requests from behavioral health supervisory staff and/or courts.

Section 11 Eligibility

- 11.1 Eligibility for services under this Human Care Agreement shall be determined and re-determined by the District, as applicable, in accordance with prescribed procedures. The provider shall be subject to a written determination that it is qualified to provide the services and shall continue the same level of qualifications, subject to a review by the District, according to the criteria delineated in 27 DCMR, Chapter 19, Section 1905.6, as amended which is incorporated into this Agreement as Attachment 41.3.

Section 12 Compliance with Laws

- 12.1 As a condition of the Provider's obligation to perform for the District's under this Agreement, the Provider shall comply with all applicable District, federal and other state and local governmental laws, regulations, standards, or ordinances and, where applicable, any other applicable licensing and permit laws, regulations, standards, or ordinances as necessary for the lawful provision of the services required of the Provider under the terms of this Human Care Agreement.

Section 13 Human Care Service Delivery and Performance

- 13.1 The term of this Human Care Agreement shall be for a period of one(1) base year and four (4) additional option years subject to an agreement of the parties, subject to the continuing availability of funds for any period beyond the end of the fiscal year in which this Agreement is awarded.
- 13.2 If the Provider fails to perform its obligations under this Human Care Agreement in accordance with the Agreement and in a timely manner, or otherwise violates any provision of this Human Care Agreement, the District may terminate this Human Care Agreement for default or convenience of the District upon serving written notice of termination to the Provider in accordance with sections 6, 8 or 16 of the Government of the District of Columbia Standard Contract Provisions For Use With District of Columbia Government Supply and Services, dated July 2010, hereafter referred to as "Standard Contract Provisions", which is incorporated into this Agreement by reference.
- 13.3 The District reserves the right to cancel a task order issued pursuant to this Human Care Agreement upon thirty (30) days written notice to the Provider.

Section 14 Agreement Not A Commitment of Funds or Commitment to Purchase

14.1 This Agreement is not a commitment by the District to purchase any quantity of a particular good or service covered under this Human Care Agreement from the Provider. The District shall be obligated only to the extent that authorized purchases are actually made by purchase order or task order pursuant to this Human Care Agreement.

Section 15 Option to Extend Term of the Agreement

15.1 The District Government may extend the term of this Human Care Agreement for a period of four (4) one (1) year option periods, or fractions thereof, by written notice to the Provider prior to the expiration of the Agreement; provided that the District gives the Provider written notice of its intent to extend at least thirty (30) days before the Human Care Agreement expires. The preliminary notice does not commit the District to an extension. . The Provider may waive the thirty (30) day notice requirements by providing a written notice to the Contracting Officer.

15.2 The service rates for the option periods shall be as specified in Section 2, Human Care Services and Service Rates.

15.3 If the District exercises an option, the extended Human Care Agreement shall be considered to include this option provision.

15.4 The total duration of this Human Care Agreement including the exercise of any options under this clause shall not exceed five (5) years.

Section 16 Contracting Officer

16.1 The Contracting Officer (CO) is the only District official authorized to bind contractually the District through signing a human care agreement or contract, and all documents relating to the human care agreement. All correspondence to the Contracting Officer shall be forwarded to: Joseph Stewart, Contracting Officer, Office of Contracting and Procurement Human Care Services Group 441 4th Street, N.W. Suite 700 South Washington, D.C. 20001 Telephone Number: (202) 724-8759 and E-Mail: Joseph.stewart@dc.gov

Section 17 Contract Administrator

17.1 The Contract Administrator (CA) is the representative responsible for the general administration of this Human Care Agreement and advising the Contracting Officer as to the compliance or noncompliance of the provider with this Human Care Agreement. In addition, the Contracting Officer's Representative is responsible for the day-to-day monitoring and supervision of this Agreement. The Contracting Officer's representative is not authorized or empowered to make amendments, changes, or revisions to this agreement. The CA shall be appointed by the Office of Contracts and Procurement at the time that the Human Care Agreement is awarded to the individual providers.

Section 18 Contact Person

- 18.1 For information concerning this Human Care Agreement contact: Mr. Dwight Hayes, Contract Specialist, Office of Contracting and Procurement 441 4th St., NW, Suite 706 North Washington, D. C. 20001 Telephone Number: (202) 727-2354 and E-Mail: dwight.hayes@dc.gov

Section 19 Ordering and Payment

- 19.1 The Provider shall not provide services or treatment under this Agreement unless the Provider is in actual receipt of a purchase order or task order for the period of the service or treatment that is signed by the Contracting Officer.
- 19.2 All purchase orders or task orders issued in accordance with this Agreement shall be subject to the terms and conditions of this Agreement. In the event of a conflict between a purchase order or a task order and this Agreement, the Agreement shall take precedence.
- 19.3 The Provider shall forward or submit all monthly invoices for each referral for services to the agency, office, or program requesting the specified human care service and as specified on page one (1) of the purchase order/task order, "Provider Shall Submit All Invoices To: Department of Youth Rehabilitation Services Office of the Chief Financial Officer 64 New York Ave., NE, 6th Floor Washington., D.C. 20002
- 19.4 To ensure proper and prompt payment, each invoice for payment shall provide the following minimum information: (1) Provider name and address; (2) Invoice date, number and the total amount due; (3) Period or date of service; (4) Description of service; (5) Quantity of services provided or performed (6) Contract line item number (CLIN) , as applicable to each purchase order or task order; (7) Purchase order or task order number; (8) Agreement number; (9) Federal tax identification number (TIN); (10) Any other supporting documentation or information, as required; (11) Name, title and telephone signature of the preparer; (12) Identification of each recipient of chore aide/emergency caretaker service; (13) The recipient's authorization number and census track; (14) The APS supervisor or social worker responsible for the case; (15) The weekly authorization for the number of ours of service that is authorized for each client; (16) The specific dates and the hours for which serve was rendered for each client; (17) The total cost for each client; and (18) The itemized information for all miscellaneous expenditure.
- 19.5 Payment shall be made only after performance by the Provider under the Agreement as a result of a valid purchase order or task order of the agreement, or the purchase order/task order, in accordance with all provisions thereof.

Section 20 Inspection and Acceptance

- 20.1** The inspection and acceptance requirements for the resultant agreement shall be governed by the Inspection of Services Clause § 7 of the Government of the District of Columbia 's Standard Contract Provisions for use with Supplies and Services Contracts, dated July 2010, located at www.ocp.dc.gov.
- 20.2** The Provider shall permit persons duly authorized by the Contracting Officer to inspect any records, papers, documents, facilities, and/or goods and services of the Provider which are relevant to the human care agreement, and/or to interview any program participants and employees of the Provider to assure the District of the satisfactory performance of the terms and conditions of the task order resulting from this human care agreement.
- 20.3** Following such evaluation, the CA will deliver to the Provider a written report of its findings and will include written recommendations with regard to the Provider's performance of the terms and conditions of the contract.
- 20.4** The Provider will correct all noted deficiencies identified by the CA within specified period of time set forth in the recommendations.
- 20.5 Inspection and Acceptance-deficiencies**
- 20.5.1** The Provider's failure to correct noted deficiencies may, at the sole and exclusive discretion of the Contracting Officer, result in any one or any combination of the following:
- 20.5.2** The Provider being deemed in breach or default of this agreement.
- 20.5.3** The withholding of payments to the Provider by the District.
- 20.5.4** The termination of the Agreement for cause.

Section 21 Standard Contract Provisions Incorporated by Reference

- 21.1** The Government of the District of Columbia Standard Contract Provisions For Use With District of Columbia Government Supply and Services, dated July 2010, hereafter referred to as the "Standard Contract Provisions" are incorporated by reference into this Agreement, and shall govern the relationship of the parties as contained in this Agreement. By signing this Agreement, the Provider agrees and acknowledges its obligation to be bound by the Standard Contract Provisions, and its requirements.

Section 22 Laws and Regulations Incorporated by Reference

- 22.1** By signing this Agreement, the Provider certifies, attests, agrees, and acknowledges to be bound by the following stipulations, representations and requirements of the provisions of the following laws, acts and orders, together with the provisions of the applicable regulations made

pursuant to the laws, and they are incorporated by reference into this Agreement:

Section 23 Child and Youth, Safety and Health Omnibus Amendment Act of 2004

23.1 The Provider agrees to comply with Title II of the Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law 15-353; DC Official Code § 4-1501.01 *et seq.*)(2006 Supp.), as amended by Title II of the Omnibus Public Safety Amendment Act of 2006, effective April 24, 2007 (D.C. Law 16-306; 54 DCR 6577) and its implementing regulations at Chapter 5 of 27 DCMR.

Section 24 District of Columbia Interstate Compact

24.1 Youth accepted for placement in facilities outside of the District, who are under the age of 18 will be referred and approved for placement by District of Columbia Interstate Compact for Placement of Children.

Section 25 Confidentiality

25.1 All services or treatment provided by the Provider through referrals by the District to the Provider shall be provided in a confidential manner and the Provider shall not release any information relating to a recipient of the services or otherwise as to the provision of those services or treatment to any individual other than an official of the District connected with the provision of services under this Human Care Agreement, except upon the written consent of the individual referral, or in the case of a minor, the custodial parent or legal guardian of the individual referral.

Section 26 Tax Compliance Certification

26.1 In signing and submitting this Human Care Agreement and the Tax Certification Affidavit, the Provider certifies, attests, agrees, and acknowledges that the Provider is in compliance with all applicable tax requirements of the District of Columbia and shall maintain that compliance for the duration of the Agreement.

Section 27 Amendments

27.1 This Human Care Agreement, including the Provider's CQR (Attachment 39.2.1), applicable documents and attachments incorporated by reference constitutes the entire Agreement between the parties and all other communications prior to its execution, whether written or oral, with reference to the subject matter of this Agreement are superceded by this Human Care Agreement. The Contracting Officer may, at any time, by written order and without notice to a surety, if any, make amendments or changes in the agreement within the general scope, services, or service rates of the Agreement. No amendment to this Agreement shall be valid unless approved in writing by the Contracting Officer, subject to any other approvals required in accordance with the District regulations at 27 DCMR. Except that the Contracting Officer may make purely clerical or administrative revisions to the Agreement with written notice to the Provider.

Section 28 Subcontracts

28.1 The Provider shall not subcontract any of the work or services provided in accordance with this Agreement to any subContractor without the prior written consent of the Contracting Officer. Any work or service that may be subcontracted shall be performed pursuant to a written subcontract agreement, which the District shall have the right to review and approve prior to its execution. Any such subcontract shall specify that the Provider and the sub- Provider shall be subject to every provision of this Human Care Agreement. Notwithstanding any subcontract approved by the District, the Provider shall remain solely liable to the District for all services required under this Human Care Agreement.

Section 29 Provider Responsibility

29.1 The Provider bears primary responsibility for ensuring that the Provider fulfills all its Human Care Agreement requirements under any task order or purchase order that is issued to the Provider pursuant to this Human Care Agreement.

29.2 The Provider shall notify the District immediately whenever the Provider does not have adequate staff, financial resources, or facilities to comply with the provision of services under this Human Care Agreement.

29.3 The Provider's employees shall report all unusual incidents on the Unusual Incident Report, including allegations of abuse or neglect, involving any client that is provided with services by the Provider by telephone to DYRS, and followed up by a written report to DYRS within forty-eight (48) hours of the unusual incident.

Section 30 Publicity

30.1 The Provider shall at all times obtain the prior written approval from the Contracting Officer before it, any of its officers, agents, employees or subcontractors, either during or after expiration or termination of the contract, make any statement, or issue any material, for publication through any medium of communication, bearing on the work performed or data collected under this Agreement.

Section 31 Conflict of Interest

31.1 No official or employee of the District of Columbia or the Federal Government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this Agreement shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the agreement or proposed agreement. (DC Procurement Practices Act of 1985, D.C. Law 6-85, D.C. Code Section 1-1190.1 and Chapter 18 of the DC Personnel Regulations).

31.2 The Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Provider further covenants not to employ any person having such

known interests in the performance of the agreement.

Section 32 Department of Labor Wage Determinations

32.1 The Provider shall be bound by Wage Determination No. 2005-2103, Revision No.13, dated June 19, 2013, incorporated herein as Attachment 41.6, issued by the U.S. Department of Labor in accordance with the Service Contract Act of 1965, as amended (41 U.S.C. 351). The Provider shall be bound by the wage rates for the term of the contract. If an option is exercised, the Provider shall be bound by the applicable wage rate at the time of the option. If the option is exercised and the Contracting Officer for the option obtains a revised wage determination, that determination is applicable for the option period(s); the Provider may be entitled to an equitable adjustment.

Section 33 Access to Records

33.1 The Provider shall retain all case records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the human care agreement for a period of five (5) years after termination of the human care agreement, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of the contract.

33.3 Persons duly authorized by the Contracting Officer shall have full access to and the right to examine any of the Provider's human care agreement and related records and documents, regardless of the form in which kept, at all reasonable times for as long as records are retained.

Section 34 Way to Work Amendment Act of 2006-Living Wage Notice

34.1 Available at www.ocp.dc.gov, click on OCP Policies and Procedures under the heading 'e-Library', then click on 'Way to Work Amendment Act Notice'.

Section 35 Way to Work Amendment Act of 2006-Living Wage Fact Sheet

35.1 Available at www.ocp.dc.gov, click on OCP Policies and Procedures under the heading 'e-Library', then click on 'Way to Work Amendment Act Fact Sheet'.

Section 36 HIPAA Privacy Compliance

36.1 Please reference the HIPAA Privacy Compliance Policy at www.ocp.dc.gov, click on OCP Policies and Procedures under the heading e-Library, then click on HIPAA Privacy Compliance Policy Clause.

Section 37 CRIMINAL BACKGROUND AND TRAFFIC RECORDS CHECKS FOR CONTRACTORS THAT PROVIDE DIRECT SERVICES TO CHILDREN OR YOUTH

A. A Provider that provides services as a covered child or youth services provider, as defined in section 202(3) of the Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law 15-353; D.C. Official Code

§ 4-1501.01 *et seq.*), as amended (in this section, the “Act”), shall obtain criminal history records to investigate persons applying for employment, in either a compensated or a volunteer position, as well as its current employees and volunteers. Annually, the provider shall request results of the criminal background checks for all employees, contractors and volunteers working with DYRS youth.

- B)** Annually, the provider shall also obtain current driver’s license and driving records to investigate persons applying for employment, as well as current employees, contractors and volunteers, when that person will be required to drive a motor vehicle to transport children in the course of performing his or her duties.
- C)** The Provider shall inform all applicants requiring a criminal background check that the results of the applicant’s criminal background check must be before the applicant may be offered a compensated position or volunteer position.
- D)** The Provider shall inform all applicants requiring a traffic records check that a traffic records check must be received on the applicant before the applicant may be offered a compensated position or a volunteer position.
- E)** The provider shall obtain from each applicant, employee, contractor and volunteer:
 - 1) a written authorization which authorizes the District and National Crime Information Center (NCIC) to conduct a criminal background check;
 - 2) a written confirmation stating that the Provider has informed him or her that the District and National Crime Information Center (NCIC) is authorized to conduct a criminal background check;
 - 3) a signed affirmation stating whether or not they have been convicted of a crime, pleaded nolo contendere, are on probation before judgment or placement of a case upon a stet docket, or have been found not guilty by reason of insanity, for any sexual offenses or intra-family offenses in the District or their equivalent in any other state or territory, or for any of the following felony offenses or their equivalent in any other state or territory:
 - (i) Murder, attempted murder, manslaughter, or arson;
 - (ii) Assault, assault with a dangerous weapon, mayhem, malicious disfigurement, or threats to do bodily harm;
 - (iii) Burglary;
 - (iv) Robbery;
 - (v) Kidnapping;
 - (vi) Illegal use or possession of a firearm;
 - (vii) Sexual offenses, including indecent exposure; promoting, procuring, compelling, soliciting, or engaging in prostitution; corrupting minors (sexual relations with children); molesting; voyeurism; committing sex acts in public; incest; rape; sexual assault; sexual battery; or sexual abuse;

- but excluding sodomy between consenting adults;
 - (viii) Child abuse or cruelty to children; or
 - (ix) Unlawful distribution of or possession with intent to distribute a controlled substance;
 - 4) a written acknowledgement stating that the Provider has notified them that they are entitled to receive a copy of the criminal background check and to challenge the accuracy and completeness of the report; and
 - 5) a written acknowledgement stating that the Provider has notified them that they may be denied employment or a volunteer position, or may be terminated as an employee or volunteer based on the results of the criminal background check.
- F)** The provider shall inform each applicant, employee, and contractor and volunteer that a false statement may subject them to criminal penalties.
- G)** Prior to requesting a criminal background check, the Provider shall provide each applicant, employee, contractor or volunteer with a form or forms to be utilized for the following purposes:
- 1) To authorize the Metropolitan Police Department (MPD), or designee, to conduct the criminal background check and confirm that the applicant, employee, contractor or volunteer has been informed that the Provider is authorized and required to conduct a criminal background check;
 - 2) To affirm whether or not the applicant, employee, contractor or volunteer has been convicted of a crime, has pleaded nolo contendere, is on probation before judgment or placement of a case upon a stet docket, or has been found not guilty by reason of insanity for any sexual offenses or intra-family offenses in the District or their equivalent in any other state or territory of the United States, or for any of the felony offenses described in paragraph H.11.5(C);
 - 3) To acknowledge that the applicant, employee, contractor or volunteer has been notified of his or her right to obtain a copy of the criminal background check report and to challenge the accuracy and completeness of the report;
 - 4) To acknowledge that the applicant may be denied employment, assignment to, or a volunteer position for which a criminal background check is required based on the outcome of the criminal background check; and
 - 5) To inform the applicant, contractor, volunteer or employee that a false statement on the form or forms may subject them to criminal penalties pursuant to D.C. Official Code §22-2405.
- H)** The Provider shall direct the applicant, contractor, volunteer or employee to complete the form or forms and notify the applicant, contractor, volunteer or employee when and where to report to be fingerprinted.

- D)** Unless otherwise provided herein, the Provider shall request criminal background checks from the Chief, MPD (or designee), who shall be responsible for conducting criminal background checks, including fingerprinting.
- J)** The Provider shall request traffic record checks from the Director, Department of Motor Vehicles (DMV) (or designee), who shall be responsible for conducting traffic record checks.
- K)** The Provider shall provide copies of the results of all criminal background and traffic check reports to the Contract Administrator (CA) within one business day of receipt.
- L)** The Provider shall pay for the costs for the criminal background and traffic record checks, pursuant to the requirements set forth by the MPD and DMV. The District shall not make any separate payment for the cost of criminal background and traffic record checks.
- M)** The Provider shall make an offer of appointment to, or assign a current employee or applicant to, a compensated position contingent upon receipt from the contracting officer of the CA's decision after his or her assessment of the criminal background or traffic record check.
- N)** The Provider shall not make an offer of appointment to a volunteer or contractor whose position brings him or her into direct contact with children until it receives from the contracting officer the CA's decision after his or her assessment of the criminal background or traffic record check.
- O)** The Provider shall not employ or permit to serve as a volunteer or contractor an applicant or employee who has been convicted of, has pleaded nolo contendere to, is on probation before judgment or placement of a case on the stet docket because of, or has been found not guilty by reason of insanity for any sexual offenses involving a minor.
- P)** Unless otherwise specified herein, the Provider shall conduct annual criminal background checks upon the exercise of each option year of this contract for current employees, contractors and volunteers .
- Q)** An employee, contractor or volunteer may be subject to administrative action including, but not limited to, reassignment or termination at the discretion of the CA after his or her assessment of a criminal background or traffic record check.
- R)** The CA shall be solely responsible for assessing the information obtained from each criminal background and traffic records check report to determine whether a final offer may be made to each applicant, volunteer, contractor or employee. The CA shall inform the contracting officer of its decision, and the contracting officer shall inform the Provider whether an offer may be made to each applicant.
- S)** If any application is denied because the CA determines that the applicant presents a present danger to children or youth, the Provider shall notify the applicant of such

determination and inform the applicant in writing that she or he may appeal the denial to the Commission on Human Rights within thirty (30) days of the determination.

- T) The provider shall institute a policy requiring employees and contractors providing direct care services to DYRS youth to submit to mandatory drug and alcohol testing during the pre-employment screening and on a random basis.
- U) Criminal background and traffic record check reports obtained under this section shall be confidential and are for the exclusive use of making employment-related determinations. The Provider shall not release or otherwise disclose the reports to any person, except as directed by the contracting officer.

SECTION 38 Insurance

38.1 A. GENERAL REQUIREMENTS. The Contractor shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall have its insurance broker or insurance company submit a Certificate of Insurance to the CO giving evidence of the required coverage prior to commencing performance under this contract. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the CO. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an Alfred M. Best Company rating of A-VIII or higher. The Contractor shall require all of its subcontractors to carry the same insurance required herein. The Contractor shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event the stated limit in the declarations page of the policy is reduced via endorsement or the policy is canceled prior to the expiration date shown on the certificate. The Contractor shall provide the CO with ten (10) days prior written notice in the event of non-payment of premium.

1. Commercial General Liability Insurance. The Contractor shall provide evidence satisfactory to the CO with respect to the services performed that it carries \$1,000,000 per occurrence limits; \$2,000,000 aggregate; Bodily Injury and Property Damage including, but not limited to: premises-operations; broad form property damage; Products and Completed Operations; Personal and Advertising Injury; contractual liability and independent contractors. The policy coverage shall include the District of Columbia as an additional insured, shall be primary and non-contributory with any other insurance maintained by the District of Columbia, and shall contain a waiver of subrogation. The Contractor shall maintain Completed Operations coverage for five (5) years following final acceptance of the work performed under this contract.
2. Automobile Liability Insurance. The Contractor shall provide automobile liability insurance to cover all owned, hired or non-owned motor vehicles used in conjunction with the performance of this contract. The policy shall provide a \$1,000,000 per occurrence combined single limit for bodily injury and property damage.
3. Workers' Compensation Insurance. The Contractor shall provide Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the contract is performed.

Employer's Liability Insurance. The Contractor shall provide employer's liability insurance as follows: \$500,000 per accident for injury; \$500,000 per employee for disease; and \$500,000 for policy disease limit.

- B. DURATION.** The Contractor shall carry all required insurance until all contract work is accepted by the District, and shall carry the required General Liability; any required Professional Liability; and any required Employment Practices Liability insurance for five (5) years following final acceptance of the work performed under this contract.

- C. **LIABILITY.** These are the required minimum insurance requirements established by the District of Columbia. **HOWEVER, THE REQUIRED MINIMUM INSURANCE REQUIREMENTS PROVIDED ABOVE WILL NOT IN ANY WAY LIMIT THE CONTRACTOR'S LIABILITY UNDER THIS CONTRACT.**
- D. **CONTRACTOR'S PROPERTY.** Contractor and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of the District of Columbia.
- E. **MEASURE OF PAYMENT.** The District shall not make any separate measure or payment for the cost of insurance and bonds. The Contractor shall include all of the costs of insurance and bonds in the contract price.
- F. **NOTIFICATION.** The Contractor shall immediately provide the CO with written notice in the event that its insurance coverage has or will be substantially changed, canceled or not renewed, and provide an updated certificate of insurance to the CO.
- G. **CERTIFICATES OF INSURANCE.** The Contractor shall submit certificates of insurance 10 business days after award of notice giving evidence of the required coverage as specified in this section prior to commencing work. Evidence of insurance shall be submitted to:

James A. Webb, Jr.
Contracting Officer
Office of Contracting and Procurement
441 4th Street, NW, Suite 700S
Washington, DC 20001
Telephone: 202-724-4019
E-mail address: james.webb@dc.gov

- H. **DISCLOSURE OF INFORMATION.** The Contractor agrees that the District may disclose the name and contact information of its insurers to any third party which presents a claim against the District for any damages or claims resulting from or arising out of work performed by the Contractor, its agents, employees, servants or subcontractors in the performance of this contract.

Section 39 Access to Records

- 39.1** The Provider shall retain all case records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the human care agreement for a period of five (5) years after termination of the human care agreement, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of the contract.

- 39.2 The Provider shall assure that these records shall be subject at all reasonable times to inspection, review, or audit by Federal, District, or other personnel duly authorized by the Contracting Officer.
- 39.3 Persons duly authorized by the Contracting Officer shall have full access to and the right to examine any of the Provider's human care agreement and related records and documents, regardless of the form in which kept, at all reasonable times for as long as records are retained.

F.40 Documents Incorporated by Reference and Order of Precedence

A conflict in language shall be resolved by giving precedence to the document in the highest order of priority that contains language addressing the issue in question. The following documents are incorporated into the human care agreement by reference and made a part of the human care agreement in the following order of precedence.

- F.40.1 The Human Care Agreement.
- F.40.2 Government of the District of Columbia Standard Agreement Provisions for use with the District of Columbia Government Supply and Services Contracts dated March 2007 located at www.ocp.dc.gov.
- F.40.3 U.S. Department of Labor Wage Determination No. 2005-2103, Revision 13, dated June 19, 2013.
- F.40.4 Living Wage Fact Sheet.
- F.40.5 The Contractor Qualifications Record completed by the Provider.
- F.40.6 Task Order or Purchase Order

F.41 Attachments

The following attachments are included and incorporated by reference into this Agreement.

1. Human Care Agreement Qualification Record
2. First Source Employment Agreement
3. U.S. Department of Labor Wage Determination No. 2005-2103, Revision 13, dated June 19, 2013
4. *Living Wage Fact Sheet*
5. Living Wage Act of 2006

Exhibit 6

948 INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE

948.1 Inpatient psychiatric services for individuals under the age of twenty-two (22) may be provided by:

(a) A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

(b) A psychiatric residential treatment facility (PRTF).

948.2 Inpatient psychiatric services for individuals under the age of twenty-two (22) shall be:

(a) Provided under the direction of a physician;

(b) Provided in a facility or program described in §948.1;

(c) Provided before the individual reaches the age of twenty-two (22), or, if the individual was receiving the services immediately before reaching the age of twenty-two (22), before the earlier of the following:

(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches the age of twenty-two (22).

(d) Certified in writing to be necessary in the setting in which the services shall be provided or are being provided in emergency circumstances in accordance with 42 CFR 441.152; and

(e) Meet the conditions of participation governing the use of restraint or seclusion set forth in 42 CFR 483.350 *et seq.*, if services are provided by a PRTF.

948.3 For each Medicaid beneficiary or applicant who is admitted to a facility or program, the certification required pursuant to §948.2(d) shall be made by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness and has knowledge of the beneficiary's health status. For an individual who applies for Medicaid while in the facility or program, the certification shall be made by the team responsible for the plan of care as described in §948.6 and shall cover any period before application for which claims are made. For emergency admissions, the certification shall be made by the team responsible for the plan of care within fourteen (14) days after admission.

948.4 A PRTF shall:

- (a) Be licensed in the state where the facility is located, if required by the state;
- (b) Have a current written provider agreement with the District of Columbia Medicaid Program;
- (c) Have a written individual plan of care for each patient as described in §948.5, developed by an interdisciplinary team of physicians and other professionals as described in §948.6 in consultation with the patient and his or her parents, legal guardians, or others in whose care the patient will be released after discharge; and
- (d) Maintain appropriate administrative and medical records for a minimum of six (6) years beyond the age of twenty-two (22) years and make such records available to officials of the Department of Health Care Finance, the Department of Mental Health, Department of Health, or other governmental officials of District, state, or federal agencies, or their designees.

948.5 Each facility or program shall have a written plan of care for each beneficiary that complies with the requirements set forth in 42 CFR 441.155 and include the following:

- (a) A certification of need for services that meets the requirements of 42 CFR 441.152;
- (b) An assessment of the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- (c) An assessment of the resources of the beneficiary's family, including parents, legal guardians, or others into whose care the beneficiary will be released after the discharge;
- (d) The establishment of treatment objectives; and
- (e) The prescribing of therapeutic modalities to achieve the plan's objectives.

948.6 The interdisciplinary team consisting of physicians and other personnel that develops an individual plan of care shall:

- (a) Be employed by the facility directly or under contract;

(b) Have demonstrated competency in child psychiatry (for example, residency in child and adolescent psychiatry and experience in inpatient child and adolescent inpatient/residential treatment settings);

(c) Include at a minimum:

- (1) A board-certified or board-eligible psychiatrist;
- (2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- (3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association; and

(d) Include one (1) of the following:

- (1) A psychiatric social worker;
- (2) A registered nurse who has specialized training or one (1) year of experience in treating mentally ill individuals;
- (3) An occupational therapist who is licensed, if required by the state, and has specialized training or one (1) year of experience in treating mentally ill individuals; or
- (4) A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

948.7 Each facility or program shall not admit a District Medicaid beneficiary or applicant unless the admission has been certified as medically necessary by the District of Columbia Department of Mental Health (DMH).

948.8 Each facility or program shall provide active treatment consistent with the requirements set forth in 42 CFR 441.155.

948.9 The written plan of care shall be developed within fourteen (14) days of admission and reviewed at least every thirty (30) days thereafter.

948.10 Each PRTF shall provide to the requesting District child-serving agency the initial plan of care and any subsequent treatment plan adjustments, including all thirty (30) day reviews of the plan of care.

SOURCE: Final Rulemaking published at 37 DCR 6812 (October 26, 1990); as amended by Final Rulemaking published at 50 DCR 7176 (August 29, 2003); as amended by Final Rulemaking published at 57 DCR 1709 (February 26, 2010) and corrected at 57 DCR 1892 (March 5, 2010).

Exhibit 7

NCTSN

The National Child
Traumatic Stress Network



Trauma-Informed Interventions:

Clinical and Research Evidence and Culture-Specific Information Project



Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project

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Methodology

In 2005, the NCTSN began compiling a list of *Empirically Supported Treatments and Promising Practices*, including interventions being implemented by sites within the NCTSN for traumatized children and their families. Treatment developers were asked to complete an intervention template, which solicited specific information about their interventions (e.g., treatment description, target population, research evidence). Fact Sheets detailing each approach were developed from each completed intervention template, and then posted on the NCTSN website for public use. The interventions and treatments selected span a continuum of evidence-based interventions for use with trauma-affected youth, ranging from rigorously evaluated interventions to promising and newly emerging practices.

In June 2006, revised intervention templates were sent to all developers of the NCTSN's *Empirically Supported Treatments and Promising Practices*. Tailored for the *Trauma Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project*, the questions on these revised intervention templates were designed to elicit information about the cultural competence of an intervention as well as the level of research supporting the treatment. We placed special emphasis on providing this level of detail about the interventions to assist practitioners' selection of which treatment or practice to implement—based not only on their levels of evidence but also on their appropriateness for a given community and target population.

Therefore, the revised intervention templates sent to developers in 2006 included questions designed to evaluate the extent of both clinical and research evidence supporting the use of trauma-informed treatment interventions with trauma-affected youth from diverse cultural groups (as defined by race, ethnicity, sexual orientation, socioeconomic status, spirituality, disability, geographic location and other factors). These questions were intended to elicit information about each of the following categories (see Appendix A, General Information Intervention Template):

- Treatment Description
- Target Population
- Essential Components
- Clinical & Anecdotal Evidence
- Research Evidence
- Outcomes
- Implementation Requirements & Readiness
- Training Materials & Requirements
- Pros & Cons/Qualitative Impressions
- Contact Information
- References

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Expert Panel Meeting

The rating system originally developed for this project was based very closely on the criteria used for *Child Physical and Sexual Abuse: Guidelines for Treatment* (2004). Those guidelines were developed by the Office for Victims of Crime, in collaboration with the National Crime Victims Research and Treatment Center at MUSC and the Center for Sexual Assault and Traumatic Stress at Harborview Medical Center. However, at the February, 2007 meeting, the expert panel concluded that the intervention Fact Sheets did not include enough information to provide a ranking for each treatment's level of cultural competence. Additionally, panel members raised concerns about the classification system, and expressed discomfort with categorizing interventions by assigning numerical ratings and citing inadequate information on specific ways in which the treatments address diverse cultural groups. The panel agreed that, rather than rating interventions based on the level of clinical and research evidence, it would be more helpful to solicit additional information about the degree to which cultural issues are addressed in the treatment intervention. The panel agreed that this would help more accurately capture the "cultural competence" of a given treatment.

As a result of these concerns, the panel decided to create a Culture-Specific Information Intervention Template. The panel spent the remainder of the meeting identifying additional culture-specific questions necessary to help determine the extent to which a particular treatment addresses the needs of diverse cultural groups. The panel decided that, once these Culture-Specific Information Intervention Templates were completed, the project would aim to present Culture-Specific Fact Sheets, alongside General Fact Sheets, in a comprehensive document.

Based on the culture-specific questions generated at the expert panel meeting, the Culture-Specific Information Intervention Template was developed and was sent to treatment developers to complete. This template included questions intended to address the following categories (see Appendix B, Culture-Specific Information Intervention Template):

- Engagement
- Language Issues
- Symptom Expression
- Assessment
- Cultural Adaptations
- Intervention Delivery Method/Transportability & Outreach
- Training Issues
- References

The information collected on the revised General Information Intervention Template as well as the Culture-Specific Intervention Template was used to create General and Culture-Specific Fact Sheets for each intervention. These Fact Sheets were then posted on the NCTSN website.

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Conclusion

There is no one treatment intervention appropriate for all children who have experienced trauma. However, there are evidence-supported treatments and promising practices that share core principles of “culturally competent trauma-informed therapy,” and that are appropriate for many children and families from diverse cultural groups.

Culturally competent trauma-informed therapies should include some, or all, of the following principles:

- **Engagement with the child, the family, and the community.** For many cultural groups, there may be cultural barriers to accessing treatment. Therefore, the start of treatment should begin with addressing strategies designed to engage children and families. These engagement strategies should be culture-specific. For example, addressing issues of trust may be important when working with refugees. Engagement strategies may also consider the role of other members of the family's immediate community, such as cultural or spiritual leaders, in reaching the child and family.
- **Sensitivity to the family's cultural background when building a strong therapeutic relationship.** Like most forms of therapy, trauma treatment requires the skillful development of a clinical relationship with the child and caregivers. During the process of building the therapeutic relationship, the practitioner must understand the importance of asking questions in order to learn about the child and/or family's cultural background.
- **Consideration of the impact of culture on symptom expression.** Most trauma-informed therapy includes a component that helps the child and caregivers identify and understand normal human reactions to trauma. When assessing reactions to trauma, it is important to consider the impact of culture, since cultural views may have an impact on symptom expression. If it is known that culture impacts symptom expression for a particular cultural group, assessment measures should reflect these differences.
- **Careful use of interpreters, when necessary.** Caregivers are typically powerful mediators of the child's treatment for and recovery from trauma. Involving the parent, resource parent, or other caregiver is a vital element of trauma treatment. Some trauma-informed interventions include a parenting component to give the parent greater mastery of child management skills. Language issues may sometimes arise if the clinician does not speak the parents' language. In such cases, it is very important to consider how the chosen treatment suggests use of interpreters in the absence of bilingual clinicians.
- **Understanding that differences in emotional expression exist among cultures.** To help with emotional regulation, it is typically necessary to teach the child (and sometimes the caregiver) practical skills and tools for gaining mastery of the overwhelming emotions often associated with trauma and its reminders. Again, it is important to assess cultural norms

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Future Directions

The purpose of the *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* was to identify trauma-focused interventions that have been developed and applied to trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence and the level of clinical and research evidence supporting the treatment. Work on this project has revealed that significant groundwork has been established in this area by clinicians and researchers working directly with trauma-affected culturally diverse populations. However, more work will be required to improve the state of the science for the identification and application of evidence-based interventions with such populations. Advancing the science could be accomplished in a number of ways, as listed below.

First, developers of the interventions described in the Fact Sheets included in this report should seek to bring their respective interventions to the next level of evaluation. This may involve more rigorous collection of pre- and post-treatment outcome data with standardized, culturally appropriate measures. In some cases, assessment approaches may require modification in order to capture this data for a particular population. (See de Arellano & Danielson, 2008, for suggestions on culturally-informed trauma assessment.) For other interventions, developers may consider conducting a more rigorous open pilot trial or a randomized controlled trial. For the limited number of trauma-informed interventions that have been conducted with culturally diverse populations, treatment developers are encouraged to pursue ways in which to measure “real world” effectiveness—perhaps by designing and conducting community-based trials. Appendix C lists criteria for evaluating levels of evidence for interventions’ use with specific cultural groups based on those used in previous treatment guidelines projects (Saunders, Berliner & Hanson, 2004) and can help provide suggested next steps for increasing the evidence base for interventions.

Another important future direction for this project may involve collaborations between community-based clinicians and researchers in order to develop a feasible “gold standard” for evaluation of trauma-informed interventions with culturally diverse populations. This pairing of science and practice could help address findings from previous reports that ethnic minority individuals and other culturally diverse youth are less likely to receive empirically-supported, gold-standard mental health interventions (U.S. Department of Health and Human Services, 2001).

Finally, it is hoped that this project will represent a first step in the continually evolving goal of developing a stronger clinical and research base for interventions used with culturally diverse populations. The Fact Sheets provided in this report are a resource that can be used to assist practitioners in the identification of interventions that have demonstrated efficacy in their application with culturally diverse populations. As clinicians continue to use interventions with diverse populations and document their clinical and research outcomes, the information on the effectiveness and efficacy of interventions for specific populations will grow and strengthen. A more formal evaluation of the state of the science, perhaps using the criteria listed in Appendix C, could then be pursued.

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Appendix A: General Information Intervention Template

 ACRONYM: Name of Intervention	
GENERAL INFORMATION	
Treatment Description	Acronym (<i>abbreviation</i>) for intervention: Average length/number of sessions: Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, transportation barriers): Trauma type (<i>primary</i>): Trauma type (<i>secondary</i>): Additional descriptors (<i>not included above</i>):
Target Population	Age range: (<i>lower limit</i>) ____ to (<i>upper limit</i>) ____ Gender: <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both Ethnic/Racial Group (<i>include acculturation level/immigration/refugee history—e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans</i>): Other cultural characteristics (e.g., SES, religion): Language(s): Region (e.g. rural, urban): Other characteristics (<i>not included above</i>):
Essential Components	Theoretical basis: Key components:
Clinical & Anecdotal Evidence	Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time). ____ This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group. <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g. quarterly/annual reports)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please include citation: Has this intervention been presented at scientific meetings ? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please include citation(s) from last five presentations: Are there any general writings which describe the components of the intervention or how to administer it? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Appendix A: General Information Intervention Template

 ACRONYM: Name of Intervention	
GENERAL INFORMATION	
Training Materials & Requirements	<p>List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.</p> <p>How/where is training obtained?</p> <p>What is the cost of training?</p> <p>Are intervention materials (<i>handouts</i>) available in other languages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, what languages?</p> <p>Other training materials &/or requirements (<i>not included above</i>):</p>
Pros & Cons/ Qualitative Impressions	<p>What are the pros of this intervention over others for this specific group (<i>e.g., addresses stigma re. treatment, addresses transportation barriers</i>)?</p> <p>What are the cons of this intervention over others for this specific group (<i>e.g., length of treatment, difficult to get reimbursement</i>)?</p> <p>Other qualitative impressions:</p>
Contact Information	<p>Name:</p> <p>Address:</p> <p>Phone number:</p> <p>Email:</p> <p>Website:</p>
References	

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Appendix B: Culture-Specific Information Intervention Template

 ACRONYM: Name of Intervention	
CULTURE-SPECIFIC INFORMATION	
<p>Intervention Delivery Method/ Transportability & Outreach</p>	<p>If applicable, how does this treatment address specific cultural risk factors (i.e., increased susceptibility to other traumas)?</p> <p>Is this a clinic-based treatment or is the treatment transportable (e.g., into home, community)? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?</p> <p>Are there cultural barriers to accessing this treatment (i.e., treatment length, family involvement, stigma, etc.)?</p> <p>Are there logistical barriers to accessing this treatment for specific cultural groups (i.e., transportation issues, cost of treatment, etc.)?</p> <p>Are these barriers addressed in the intervention and how?</p> <p>What is the role of the community in treatment (e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)?</p>
<p>Training Issues</p>	<p>What potential cultural issues are identified and addressed in supervision/training for the intervention?</p> <p>If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?</p> <p>If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?</p> <p>Has this guidance been provided in the writings on this treatment?</p> <p>Any other special considerations regarding training?</p>
<p>References</p>	

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Appendix C: Treatment Protocol Classification System

- d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.
- f. At least two randomized, controlled treatment outcome studies (RCTs) have found the treatment protocol to be superior to an appropriate comparison treatment, or no different nor better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The RCTs must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.
- g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

2. Supported and Probably Efficacious Treatment for Specific Cultural Groups

- a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.
- b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.
- c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.
- d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.
- f. At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time; efficacy over placebo; or, found it to be comparable to or better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The studies must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.
- g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

Exhibit 8

Dialectical Behavior Therapy Frequently Asked Questions

What is Dialectical Behavior Therapy?

Dialectical Behavior Therapy (DBT) is a treatment designed specifically for individuals with self-harm behaviors, such as self-cutting, suicide thoughts, urges to suicide, and suicide attempts. Many clients with these behaviors meet criteria for a disorder called borderline personality (BPD). It is not unusual for individuals diagnosed with BPD to also struggle with other problems – depression, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety, eating disorders, or alcohol and drug problems. DBT is a modification of cognitive behavioral therapy (CBT). In developing DBT, Marsha Linehan, Ph.D. (1993a) first tried applying standard CBT to people who engaged in self-injury, made suicide attempts, and struggled with out-of-control emotions. When CBT did not work as well as she thought it would, Dr. Linehan and her research team added other types of techniques until they developed a treatment that worked better. We'll go into more detail about these techniques below, but it's important to note that DBT is an "empirically-supported treatment." That means it has been researched in clinical trials, just as new medications should be researched to determine whether or not they work better than a placebo (sugar pill). While the research on DBT was conducted initially with women who were diagnosed with BPD, DBT is now being used for women who binge-eat, teenagers who are depressed and suicidal, and older clients who become depressed again and again.

Why do people engage in self-destructive behavior?

A key assumption in DBT is that self-destructive behaviors are learned coping techniques for unbearably intense and negative emotions. Negative emotions like shame, guilt, sadness, fear, and anger are a normal part of life. However, it seems that some people are particularly inclined to have very intense and frequent negative emotions. Sometimes, the human brain is simply "hard-wired" to experience stronger emotions, just like an expensive stereo is "hard-wired" to produce very complex sounds. Or, it could be that severe emotional or physical trauma causes changes in the brain to make it more vulnerable to intense feeling states. Additionally, sometimes clients have mood disorders – Major Depression or Generalized Anxiety -- that are not controlled by standard medications and thus lead to emotional suffering. Any one of these factors, or any combination of them, can lead to a problem called **emotional vulnerability**. A person who is emotionally vulnerable tends to have quick, intense, and difficult-to-control emotional reactions that make his or her life seem like a rollercoaster.

Extreme emotional vulnerability is rarely the sole cause of psychological problems. An **invalidating environment** is also a major contributing factor. What is an invalidating environment? The "environment," in this case, is usually other people. "Invalidating" refers to a failure to treat a person in a manner that conveys attention, respect, and understanding. Examples of an invalidating environment can range from mismatched personalities of children and parents (e.g., a shy child growing up in a family of extraverts who tease her about her shyness); to extremes of physical or emotional abuse. In DBT, we think that borderline personality disorder arises from the **transaction** between emotional vulnerability and the invalidating environment.

Back to the example of a shy child: If a shy child is teased by his siblings or forced to go into social situations he wants to avoid, he may learn to have tantrums to let others realize that he's scared. If his shyness is only taken seriously when he has an outburst, he learns (without being conscious of it) that tantrums work. He has not been "validated." In this case, forms of validation could have included telling the person that being shy is normal for some people, teaching him that shy people have to work harder to overcome social anxiety, or helping him learn skills for managing shyness so it does not interfere with his life.

This is a relatively benign example. Some individuals, however, grow up in situations where they are abused or neglected. They may learn more extreme ways of getting other people to take them seriously. Further, because they are in painful circumstances, they may learn to cope with emotional pain by thinking about suicide, cutting themselves, restricting their food intake, or using drugs and alcohol. A vicious cycle can get started: The person is really sad and scared, she has no one who listens to her, she is afraid to ask for help or knows no help is available, and so she tries to kill herself. Then, when her pain is treated seriously at the hospital, she learns (without being conscious of it) that when she's suicidal, other people understand how badly she feels. Repeated self-injury can result if it is seen as the only means for getting better or achieving understanding from other people.

What kind of therapy do clients receive in DBT?

Clients in standard DBT* receive three main modes of treatment – individual therapy, skills group, and phone coaching. In individual therapy, clients receive once weekly individual sessions that are typically an hour to an hour-and-a-half in length. Clients also must attend a two-hour weekly skills group for at least one year. Unlike with regular group psychotherapy, these skills groups emerge as classes during which clients learn four sets of important skills – Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Clients are also asked to call their individual therapists for skills coaching **prior** to hurting themselves. The therapist then walks them through alternatives to self-harm or suicidal behaviors.

It should be noted that in standard DBT, it is the individual therapist who is “in charge” of the treatment. This means it is the individual therapist’s job to coordinate the treatment with the other people – skills group leaders, psychiatrists, and vocational counselors. In collaboration with the client, the therapist keeps track of how the treatment is going, how things are going with everyone involved in the treatment, and whether or not the treatment is helping the client reach his or her goals.

In some situations, DBT clients may also be on medications for problems like major depression bipolar disorder, are transient (short-term) psychotic episodes.

What are the top targets and goals of treatment in DBT?

The most important of the overall goals in DBT is helping clients create “lives worth living.” What makes a life worth living varies from client to client. For some clients, a life worth living is getting married and having kids. For others, it’s finishing school and finding a life partner. Others might find it’s joining a religious or spiritual group and buying a house near a place of worship. While all these goals will differ, all clients have in common the task of bringing problem behaviors, especially behaviors that could result in death, under control. For this reason, DBT organizes treatment into four stages with targets. Targets refer to the problems being addressed at any given time in therapy. Here are the four stages with targeted behaviors in DBT:

Stage I: Moving from Being Out of Control of One’s Behavior to Being in Control

Target 1: Reduce and then eliminate life-threatening behaviors (e.g., suicide attempts, suicidal thinking, intentional self-harm).

Target 2: Reduce and then eliminate behaviors that interfere with treatment (e.g., behavior that “burns out” people who try to help, sporadic completion of homework assignments, non-attendance of sessions, non-collaboration with therapists, etc.). This target includes reducing and then eliminating the use of hospitalization as a way to handle crises.

* “Standard” refers to outpatient DBT as it is researched and developed at Dr. Linehan’s research lab.

Target 3: Decreasing behaviors that destroy the quality of life (e.g., depression, phobias, eating disorders, non-attendance at work or school, neglect of medical problems, lack of money, substandard housing, lack of friends, etc.) and increasing behaviors that make a life worth living (e.g., going to school or having a satisfying job, having friends, having enough money to live on, living in a decent apartment, not feeling depressed and anxious all the time, etc.).

Target 4: Learn skills that help people do the following:

- a) Control their attention, so they stop worrying about the future or obsessing about the past. Also, increase awareness of the “present moment” so they learn more and more about what makes them feel good or feel bad.
- b) Start new relationships, improve current relationships, or end bad relationships.
- c) Understand what emotions are, how they function, and how to experience them in a way that is not overwhelming.
- d) Tolerate emotional pain without resorting to self-harm or self-destructive behaviors.

Stage II. Moving from Being Emotionally Shut Down to Experiencing Emotions Fully

The main target of this stage is to help clients experience feelings without having to shut down by dissociating, avoiding life, or having symptoms of post-traumatic stress disorder (PTSD). In DBT, we say that clients entering this stage are now in control of their behavior but are in “quiet desperation.” Teaching someone to suffer in silence is not the goal of treatment. In this stage, the therapist works with the client to treat PTSD and/or teaches the client to experience all of his or her emotions without shutting the emotions down and letting the emotions take the driver’s seat.

Stage III. Building an Ordinary Life, Solving Ordinary Life Problems

In Stage III, clients work on ordinary problems like marital or partner conflict, job dissatisfaction, career goals, etc. Some clients choose to continue with the same therapist to accomplish these goals. Some take a long break from therapy and work on these goals without a therapist. Some decide to take a break and then work with a different therapist in a different type of therapy.

Stage IV. Moving from Incompleteness to Completeness/Connection

Most people may struggle with “existential” problems despite having completed therapy at the end of stage III. Even if they have the lives they wanted, they may feel somewhat empty or incomplete. Some people refer to this as “spiritual dryness” or “an empty feeling inside.” Although research on this stage is lacking, Marsha Linehan added it after realizing that many clients go on to seek meaning through spiritual paths, churches, synagogues, or temples. Clients would also change their career paths or relationships.

Although these stages of treatment and target priorities are presented in order of importance, we believe they are all interconnected. If someone kills herself, she won’t get the help that she needs to change the quality of her life. Therefore, DBT focuses on life threatening behavior first. However, if the client is staying alive but is neither coming to therapy nor doing the things required in therapy, she won’t get the help needed to solve non-life threatening problems like depression or substance abuse. For that reason, treatment-interfering behaviors are the second priority in stage I. But coming to treatment is certainly not enough. A client stays alive and comes to therapy in order to solve the other problems which are making her miserable. To truly have a life worth living, the client must learn new skills, learn to experience emotions, and accomplish ordinary life goals. Therapy is not finished until all of this is accomplished.

How is DBT different from regular Cognitive Behavioral Therapy?

DBT is a modification of standard cognitive behavioral treatment. As briefly stated above, Marsha Linehan and her team of therapists used standard CBT techniques, such as skills training, homework assignments, symptom rating scales, and behavioral analysis in addressing clients' problems. While these worked for some people, others were put off by the constant focus on change. Clients felt the degree of their suffering was being underestimated, and that their therapists were overestimating how helpful they were being to their clients. As a result, clients dropped out of treatment, became very frustrated, shut down or all three. Linehan's research team, which videotaped all their sessions with clients, began to notice new strategies that helped clients tolerate their pain and worked to make a "life worth living." As acceptance strategies were added to the change strategies, clients felt their therapists understood them much better. They stayed in treatment instead of dropping out, felt better about their relationships with their therapists, and improved faster.

The balance between acceptance and change strategies in therapy formed the fundamental "dialectic" that resulted in the treatment's name. "Dialectic" means 'weighing and integrating contradictory facts or ideas with a view to resolving apparent contradictions.' In DBT, therapists and clients work hard to balance *change* with *acceptance*, two seemingly contradictory forces or strategies. Likewise, in life outside therapy, people struggle to have balanced actions, feelings, and thoughts. We work to integrate both passionate feelings and logical thoughts. We put effort into meeting our own needs and wants *while* meeting the needs and wants of others who are important to us. We struggle to have the right mix of work and play.

In DBT, there are treatment strategies that are specifically dialectical; these strategies help both the therapist and the client get "unstuck" from extreme positions or from emphasizing too much change or too much acceptance. These strategies keep the therapy in balance, moving back and forth between acceptance and change in a way that helps the client reach his or her ultimate goals as quickly as possible.

THE THREE FUNDAMENTALS OF DBT: CBT, ACCEPTANCE, AND DIALECTICS

1) Cognitive Behavioral Therapy

CBT and DBT therapists do not think that clients can be helped through insightful discussions, although insight can be helpful at times. *Learning new behaviors* is critical in DBT and is a focus in every individual session, skills group or phone call (for coaching). "Behavior" refers to anything a person thinks, feels, or does. Cognitive behavioral therapy uses a wide variety of techniques to help people change behaviors that inhibit a "life worth living." In DBT, as in CBT, clients are asked to change. Clients track and record their problem behaviors with a weekly diary card. They also attend skills groups, complete homework assignments and role-play new ways of interacting with people when in session with their therapist. In addition, clients work with their therapist to identify how they are rewarded for maladaptive behavior or punished for adaptive behavior. They expose themselves to feelings, thoughts or situations that they feared and avoided, and they change self-destructive ways of thinking. What we have just described in layman's terms are the four main change strategies: Skills Training, Exposure Therapy, Cognitive Therapy, and Contingency Management.

A great book on one main technique in behavior therapy – contingency management – is Karen Pryor's *Don't Shoot the Dog* (Bantam Books). Karen Pryor is a dolphin trainer who opened Hawaii's first ocean park. The principles an animal behaviorist like Pryor uses to teach animals are the same principles we can use with ourselves to change ourselves and make our relationships better. Karen Pryor's book is fun, humane, and easy to understand. Contrary to popular belief, behavior therapy is not cold and technical. Rather, at its best, it is about learning to change while treating ourselves and each other with respect and kindness. If you read this book (and it can be read in an evening), you'll know a lot more about how one of the main strategies cognitive behavioral therapy works. You can also take a lot of the techniques and apply them to your life at home, work, or school.

2) Validation (Acceptance)

As we noted in the above paragraphs, cognitive behavioral therapy techniques were not enough to help clients who were suicidal and chronically self-harming in the context of Borderline Personality Disorder (BPD). It's not that the techniques were ineffective; it's just that as stand-alone interventions, they caused clients a great deal of distress. Clients found the pushing for change *invalidating*. In a simple example, it's as if therapists were saying to someone with severe burns on the soles of their feet, "just keep walking and your feet will get stronger...try not to think about the pain," though each step was excruciatingly painful, and the patient was depressed and had no experience with keeping her mind off severe pain.

Linehan and her research team discovered that when the therapist weaved an emphasis on validation with an equal emphasis on change, clients were more likely to be collaborative and less likely to become agitated and withdrawn. So what is validation? It means a number of things. One of the things it does not mean, necessarily, is agreement. For instance, a therapist could understand that a client abuses alcohol to overcome intensive social anxiety, and yet realize that when the client is drunk, he makes impulsive decisions that may lead to self-harm. The therapist could validate that: a) her behavior makes sense as the only way she's ever gotten her anxiety to go down; b) her parents always got drunk at parties; and c) sometimes when she's drunk and does something impulsive, the impulsive behavior can be "fun." In this case, the therapist can validate that the substance abuse makes sense, given the client's history and point of view. But the therapist does not have to agree that abusing alcohol is the best approach to solving the client's anxiety.

In DBT, there are several levels and types of validation. The most basic level is staying alert to the other person. This means being respectful to what she is saying, feeling, and doing. Other levels of validation involve helping the client regain confidence both by assuming that her behavior makes perfect sense (e.g. of course you're angry at the store manager because he tried to overcharge you and then lied about it) and by treating the other person as an equal (i.e., as opposed to treating her like a fragile mental patient).

In DBT, just as clients are taught to use cognitive behavioral strategies, they are also taught and encouraged to use validation. In treatment and in life, it is important to know what about ourselves we can change and what about ourselves we must accept (whether short term or the long term). For that reason, acceptance and validation skills are taught in the skills modules as well.

There are four skills modules all together - two emphasize change and two emphasize acceptance. For example, it is extremely important that clients who self-harm learn to accept the experience of pain instead of turning to self-destructive behavior to solve their problems. Likewise, clients who cut themselves, binge and purge, abuse alcohol and drugs, dissociate, etc., must learn to simply "be with" reality, as painful as it may be at any given moment, in order to learn that they "can stand it." DBT teaches a host of skills so that clients can learn to stand still instead of running away. DBT also teaches clients how to work to understand why their lives are so hard.

3) Dialectics

"Dialectics" is a complex concept that has its roots in philosophy and science. We won't go into its background here but we will attempt to explain what we mean by dialectics and give examples of thinking dialectically. "Dialectics" involves several assumptions about the nature of reality: 1) every thing is connected to everything else; 2) change is constant and inevitable; and 3) opposites can be integrated to form a closer approximation to the truth (which is always evolving). Here's a brief example about how these assumptions would come into play in a DBT program. Suppose you are silent in groups. The other group members are affected by your silence and they try to get you to talk. You affect them and they affect you. Perhaps the group pushes you so hard that you feel like quitting and you talk even less. Then the other members get tired of your silence and withdraw. Paradoxically, this makes you feel better and causes you to talk a bit more. As you become a true member of the group, the leaders shift the way they run the group in order to manage the tension between you and the other members. In other words, you are all interconnected, influencing each other in each moment.

As time passes in the group, there are inevitable changes. Perhaps the group becomes more skilled at getting you to talk. Perhaps you take some risks and talk more. Maybe a new member enters the group while an older

member of the community transitions out and the group struggles to adjust to the new arrangement. You also may become aware that your thoughts and feelings change throughout the group, as does every other group member's. You notice that the group is constantly evolving, constantly readjusting itself. Thinking dialectically means recognizing that all points of view—yours, the other members – have validity and yet all may also be wrong-headed at the same time. If the group is working together dialectically, the group leaders and the members are in constant flux, looking at how opposing points of view can be in play and yet be synthesized. In short, the group is always balancing change and acceptance. Throughout, the group leader and the members would try to hold on to the idea that everyone is doing the best he or she can AND that everyone has got to do better.

DBT also involves specific dialectical strategies to help clients get “unstuck” from rigid ways of thinking or viewing the world. Some of these are traditional Western therapy interventions and others draw on Eastern ways of viewing life. If you read Linehan's (1993a) text, you can read about these strategies in chapter seven and review the examples she gives. But here are two examples. Suppose a client makes a strong initial commitment to do a year's worth of DBT. Rather than simply saying “Hey, that's terrific!” the therapist would gently turn the tables on the client by asking, “Are you sure you want to? It's going to be very hard work.” This strategy, called “Devil's advocate,” causes the client to argue in favor of why and how she will complete the therapy and not drop out. In this case, the therapist guides the client to strengthen her (the client's) arguments for being accepted into treatment, rather than the therapist trying to convince her to stay. “Making Lemonade out of Lemons,” another strategy, also helps the clinician handle similarly tough situations. For instance, a client may complain that she absolutely hates her group therapist and wants to switch skills groups. The therapist might respond with an opposing suggestion: This can be seen as a learning opportunity in handling intense negative emotions towards authority. The therapist could then show the similarity between the client's group therapist and other persons of authority (teachers, bosses, supervisors), and demonstrate this as a chance to tolerate a person one can't stand but has to work with. As these examples illustrate, the point of all dialectical strategies is to provide movement, speed, and flow so that therapist and client do not become stuck in “I will not do that” vs. “Oh, yes you will!”

Suggested Reading

Linehan, M.M. (1993a). Cognitive behavioral therapy for Borderline Personality Disorder. New York: Guilford Press. *This is the published treatment manual for the entire treatment. Many lay-people say this is a difficult read, though very helpful. For that reason, many start by reading the skills manual listed next.*

Linehan, M. M. (1993b). Skills Training Manual for Treating Borderline Personality Disorder. New York: Guilford Press. *This manual gives an excellent overview of DBT and the skills-training in the program.*

Pryor, K. (1993). Don't Shoot the Dog! New York: Bantam Doubleday Dell Pub. *This is a great introduction to principles of learning and behaviorism by a dolphin trainer. Her techniques apply to all of us.*

Exhibit 9

SEASONS NEW HIRE TRAINING SCHEDULE	
DAY ONE: General Company Overview and Risk	
Time: 30 Minutes	<p>Topic/Lead: President's Message and Welcome/ CEO</p> <ul style="list-style-type: none"> - Organizational culture and leadership: Mission, Vision, Core Values
Time: 2 hours	<p>Topic/Lead: Human Resources Info/Director of Human Resources</p> <ul style="list-style-type: none"> - Dissemination of Handbook and Code of Conduct - Compensation/Bonus Structure - Dress Code/ID badge - Workplace Stress
Time 1.5 hours	<p>Topic/Lead: Human Resources/ Director of Human Resources</p> <ul style="list-style-type: none"> - Benefits Overview - Harassment Training (video)
Time: 3.5 hours	<p>Topic/Lead: Compliance and Risk/Director of Compliance</p> <ul style="list-style-type: none"> - Corporate Compliance - HIPAA – Privacy and Security - Incident Reporting by staff level - Fraud, Abuse and Waste: Definition and Corporate Policy - Culturally Competent Care
DAY TWO: Program Safety: Keeping Residents and Staff Safe	
Time: 2 hours Annual Training	<p>Topic/Staff Lead: Emergency Preparation: What to do in the event of a campus emergency/QC</p> <ul style="list-style-type: none"> - Fire Safety and building layout - Utility failure (gas leaks, etc.) - Weather related safety – Drills and Protocols - Proper Medical Waste Disposal: Biohazard Spills - Natural Disasters and Bomb Threats
Time 1.5 hours Annual on hire date	<p>Topic/Staff Lead: Employee Safety: Director of Nursing</p> <ul style="list-style-type: none"> - Infection Control and Disease Prevention - Employee TB shot (required)

SEASONS NEW HIRE TRAINING SCHEDULE

DAY TWO: Program Safety: Keeping Residents and Staff Safe (cont'd)

Time 2 hours	<p>Topic/Lead: Treatment Philosophy/Clinical Director and Executive Director</p> <ul style="list-style-type: none"> - Definition and Commitment to POC - Impact of Values, Beliefs, Culture, Background, Attitudes - Trauma-Informed Care – Definition and Approach - Trends and Current Evidence-Based Practices
Time: 2 hours	<p>Topic/Lead: Treatment Philosophy/Clinical Director</p> <ul style="list-style-type: none"> - Keeping Residents Safe: Understanding Behaviors - Crisis Prevention Plan: Acute Care Transfers - Documentation and Hand Off Communication - Role of Treatment Team and The Value of Staff Input

DAY THREE: Understanding Treatment Protocols

Time: 3 hours	<p>Topic/Lead: Disease State Education/Psychiatrist, Director of Nursing</p> <ul style="list-style-type: none"> - Mood and Mental Health Disorders - Side Effect or Symptom: Mental Health Medication Review
Time: 2 hours	<p>Topic/Lead: Therapeutic Approach: Director of Nursing and Milieu Manager</p> <ul style="list-style-type: none"> - Therapeutic vs. Punitive Approach - Establishing Therapeutic Boundaries - Understanding and Embracing Cultural Diversity - Collaboration with Clinical Team
Time: 3 hours Annual on hire date	<p>Topic/Lead: Patient Rights and Our Responsibility/ Clinical Director and Quality Control</p> <ul style="list-style-type: none"> - Patient Rights – Review of Handbook - Abuse and Neglect: Reporting - Seclusion and Restraints: PRTF and COMAR Regulation Review

SEASONS NEW HIRE TRAINING SCHEDULE

Day Four: Handle With Care: Class Demo w/Certified Trainers (Required)
 The following information is from the website: <http://handlewithcare.com/>

<p>Time: 8 hours Annual on Hire Date (half day review)</p>	<p>Topic and Lead: De-escalation and crisis intervention training for all direct service staff: Certified, "Handle With Care" Trainers</p>
	<ul style="list-style-type: none"> - Handle With Care (HWC) has been a leader in the field of crisis intervention, behavior management and restraint for over two decades. Developing successful Behavior Management and Physical Restraint Training models that have become the "standard of best practices" for the human services industry. - Handle With Care is a nationally recognized training program developed by a line person for all direct service staff. Handle With Care is committed to teaching staff how to deal with a behaviorally challenged population in a way that preserves the client's dignity, is safe and enables continued positive learning and behavioral development by preserving and enhancing the therapeutic relationship. - Handle With Care believes for learning/therapy to take place, there must be an established universal (staff and client) perception of physical and psychological safety in the milieu. Emotional safety is a relationship climate consisting of acceptance, trust, honesty, problem-solving skills, communication, tolerance and forgiveness.

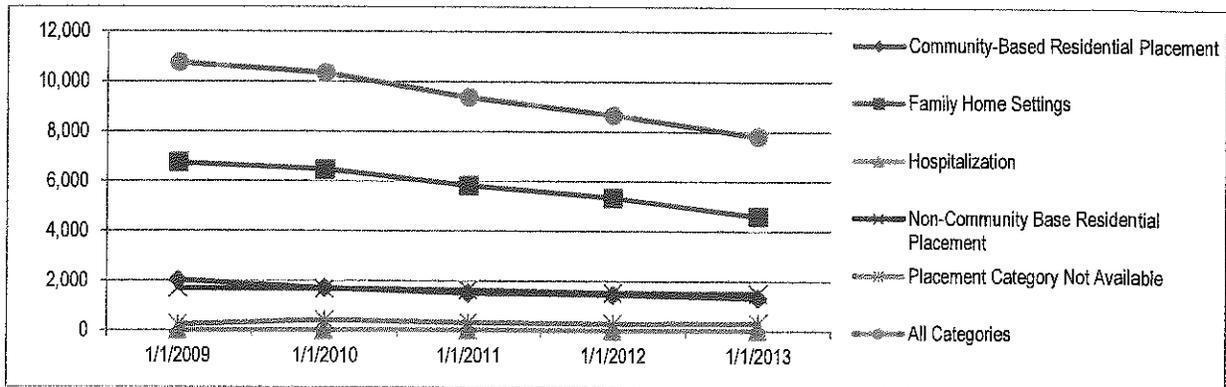
DAY FIVE: Basic First Aid (Live class with Certified Trainer)

<p>Time: 8 hours Annual on Hire date (half day class)</p>	<p>Topic and Lead: Basic First Aid Principles: American Red Cross and American Heart Association training: Certified Trainers</p> <ul style="list-style-type: none"> - Situations Requiring First Aid: Medical Emergencies - Prevailing State Guidelines and Federal Law - CPR Demonstration and Testing
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Exhibit 10

Statewide Summary

The Maryland Regulations on Out-of-Home Placement (COMAR 07.02.11) set forth the requirements of the out-of-home placement program to reduce the rate at which children enter and re-enter out-of-home placement; reduce the median length of stay in out-of-home placement; minimize the number of placement changes within 24 months of entering out-of-home placement; increase the percentage of reunifications, guardianships, and adoptions; and decrease the number of children in out-of-home placement.



Statewide Placement Trends							
Category	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
Community-Based Residential Placement	2,035	1,718	1,514	1,465	1,335	-9.9%	-8.9%
Family Home Settings	6,755	6,490	5,840	5,359	4,619	-9.0%	-13.8%
Hospitalization	29	31	43	18	31	14.9%	72.2%
Non-Community-Based Residential Placement ²	1,704	1,686	1,646	1,531	1,514	-2.9%	-1.1%
Placement Category Not Available	251	435	336	302	324	11.9%	7.3%
All Categories	10,774	10,360	9,379	8,675	7,823	-7.7%	-9.8%

Table 1

The number of children in out-of-home placement has been steadily decreasing since FY2009, and in the last year, the number decreased by more than 800. The most significant decreases have been in the Family Home Settings and Community-Based Placement categories, with an average decrease of 9% and 9.9%, respectively. It is estimated that nearly 8,000 Maryland children are in out-of-home placement on any given day.

² The number of non-community-based residential placements is higher than actual because DJS Residential Treatment Center placements (included in the number of non-community-based residential placements) are reported by DJS and MHA. DJS Residential Treatment Center placements are included in Table 68. The numbers are unchanged in Table 1 to ensure consistency between the data based on the Statewide one-day census totals, which are not disaggregated by placement subcategory.

Placing Agency	Family Home Placement						Community-Based Placement						Non-Community-Based Placement						Hospitalization Placement	
	Adoptive Care	Foster Care	Formal Relative (Kinship) Care	Restricted Relative (Kinship) Care	Treatment Foster Care	Living Arrangement - Family Home	Independent Living Programs	Residential Child Care Program	Community Supported Living Arrangement (CSLA)	Living Arrangement - Community-Based	Diagnostic Evaluation Treatment Program	Juvenile Detention and Commitment Centers	Non-Secure/Non-RTC Facilities	Residential Educational Centers	Residential Treatment Centers	Substance Abuse and Addiction Programs (ASAM)	Living Arrangement - Non-Community-Based	In-Patient Private	Psychiatric Hospitalization	
ADAA																				
DAA																				
MHA													68							
MSDE																				
DJS		5			66		18			25	185	69		179	279			9		
DHR	38	1,204	363	401	1,693	338	213	750	69					168		100	6	16		

Chart 2: State Agency Placement Categories, Placement Totals on 1/31/2013

Exhibit 11

**STRATEGIC BEHAVIORAL HEALTH, LLC
AND SUBSIDIARIES**
Memphis, Tennessee

**Consolidated Financial Statements –
Modified Cash Basis**
Years Ended December 31, 2013 and 2012

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INDEPENDENT AUDITOR'S REPORT

Members
Strategic Behavioral Health, LLC
Memphis, Tennessee

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Strategic Behavioral Health, LLC and Subsidiaries (the "Company"), which comprise the consolidated statements of assets, liabilities and members' equity on a modified cash basis as of December 31, 2013 and 2012, and the consolidated statements of revenue and expenses, changes in members' equity and cash flows on a modified cash basis for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with the modified cash basis of accounting described in Note 1; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the consolidated financial statements in the circumstances. Management is also responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk

assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

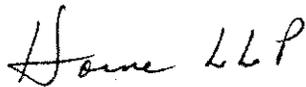
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the assets, liabilities and members' equity of the Company as of December 31, 2013 and 2012, and its revenues and expenses, changes in members' equity and cash flows for the years then ended in accordance with the modified cash basis of accounting described in Note 1.

Basis of Accounting

We draw attention to Note 1 of the consolidated financial statements, which describes the basis of accounting. The consolidated financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinions are not modified with respect to this matter.



Memphis, Tennessee
May 22, 2014

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Assets, Liabilities and Members' Equity -
Modified Cash Basis
December 31, 2013 and 2012

	2013	2012
ASSETS		
Current assets		
Cash and cash equivalents	\$ 2,271,076	\$ 2,820,508
Patient accounts receivable, net of allowance for doubtful accounts of \$2,544,167 at 2013 and \$915,540 at 2012	13,593,272	8,195,262
Due from third-party payors	215,868	-
Inventories	86,741	67,931
Prepaid expenses	1,221,325	741,435
Total current assets	<u>17,388,282</u>	<u>11,825,136</u>
Property and equipment	73,426,065	48,843,897
Less accumulated depreciation	(4,331,553)	(2,181,981)
Property and equipment, net	<u>69,094,512</u>	<u>46,661,916</u>
Goodwill	45,326,774	28,616,112
Other assets, net	1,470,620	1,080,521
Total other assets	<u>46,797,394</u>	<u>29,696,633</u>
Total assets	<u>\$ 133,280,188</u>	<u>\$ 88,183,685</u>
LIABILITIES AND MEMBERS' EQUITY		
Current liabilities		
Current maturities of long-term debt	\$ 3,072,422	\$ 1,703,039
Accounts payable	3,294,809	923,373
Accrued expenses	4,694,081	2,963,365
Due to third-party payors	-	308,918
Accrued distributions to members	155,942	439,396
Total current liabilities	<u>11,217,254</u>	<u>6,338,091</u>
Long-term debt, less current maturities	<u>65,527,959</u>	<u>40,739,559</u>
Total liabilities	<u>76,745,213</u>	<u>47,077,650</u>
Members' equity		
Members' contributions	45,915,034	36,915,034
Note receivable for members' contributions	(161,878)	(71,616)
Retained earnings	10,781,819	4,262,617
Total members' equity	<u>56,534,975</u>	<u>41,106,035</u>
Total liabilities and members' equity	<u>\$ 133,280,188</u>	<u>\$ 88,183,685</u>

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Revenues and Expenses -
Modified Cash Basis
Years Ended December 31, 2013 and 2012

	2013	2012
Revenues		
Patient service revenue (net of contractual allowances and discounts)	\$ 84,341,797	\$ 50,630,683
Provision for bad debts	(3,849,410)	(748,305)
Net patient service revenue, less provisions for bad debts	80,492,387	49,882,378
Expenses		
Salaries and benefits	47,238,842	28,084,047
Professional fees	6,129,697	3,204,772
Supplies	4,669,356	2,632,128
Management and incentive fees	754,517	1,030,560
Depreciation and amortization	2,169,598	1,211,918
Rent	967,683	880,575
Utilities	1,264,783	900,441
Insurance	618,143	409,614
Interest	2,693,906	1,604,292
Property tax	547,463	269,646
Travel	949,598	618,461
Acquisition costs	619,877	51,263
Other expenses	2,903,656	1,752,063
Total expenses	71,527,119	42,649,780
Excess of revenues over expenses - modified cash basis	\$ 8,965,268	\$ 7,232,598

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Consolidated Statements of Changes in Members' Equity -
Modified Cash Basis
Years Ended December 31, 2013 and 2012

	Members' Contributions	Note Receivable for Members' Contributions	Retained Earnings (Deficits)	Total
Balance, January 1, 2012	\$ 31,915,034	\$ (76,616)	\$ (684,519)	\$ 31,153,899
Excess of revenues over expenses - modified cash basis	-	-	7,232,598	7,232,598
Contributions	5,000,000	-	-	5,000,000
Payment on note receivable from member	-	5,000	-	5,000
Distributions to members	-	-	(2,285,462)	(2,285,462)
Balance, December 31, 2012	36,915,034	(71,616)	4,262,617	41,106,035
Excess of revenues over expenses - modified cash basis	-	-	8,965,268	8,965,268
Contributions	9,000,000	-	-	9,000,000
Issuance of note receivable from members	-	(103,185)	-	(103,185)
Payment on note receivable from members	-	12,923	-	12,923
Distributions to members	-	-	(2,446,066)	(2,446,066)
Balance, December 31, 2013	<u>\$ 45,915,034</u>	<u>\$ (161,878)</u>	<u>\$ 10,781,819</u>	<u>\$ 56,534,975</u>

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Consolidated Statements of Cash Flows -

Modified Cash Basis

Years Ended December 31, 2013 and 2012

	2013	2012
Cash flows from operating activities		
Excess of revenues over expenses - modified cash basis	\$ 8,965,268	\$ 7,232,598
Adjustments to reconcile excess of revenues over expenses (modified cash basis) to net cash provided by operating activities		
Depreciation and amortization	2,169,598	1,211,918
Amortization of debt issue costs	203,496	97,775
Provision for bad debts	3,849,410	748,305
Change in assets and liabilities		
Patient accounts receivable	(6,857,732)	(4,073,999)
Due from third-party payors	(524,786)	(308,918)
Inventories	1,859	3,263
Prepaid expenses	(455,713)	(138,945)
Other assets	(109,971)	-
Accounts payable	2,286,127	(216,607)
Accrued expenses	1,442,932	1,785,559
Net cash provided by operating activities	<u>10,970,488</u>	<u>6,340,949</u>
Cash flows from investing activities		
Acquisitions of property and equipment	(18,613,606)	(16,611,128)
Acquisition of SBH-El Paso, LLC	(24,764,177)	-
Reduction of acquisition price	-	195,501
Net cash used by investing activities	<u>(43,377,783)</u>	<u>(16,415,627)</u>
Cash flows from financing activities		
Debt proceeds received	77,030,626	7,915,203
Repayment of long-term debt	(50,872,843)	(1,334,616)
Cash contributions from members	8,896,815	5,000,000
Payments of debt issuance costs	(482,874)	(416,810)
Proceeds received on members' note receivable for contributions	12,923	5,000
Cash distributions to members	(2,726,784)	(2,377,177)
Net cash provided by financing activities	<u>31,857,863</u>	<u>8,791,600</u>
Net decrease in cash and cash equivalents	(549,432)	(1,283,078)
Cash and cash equivalents, beginning of year	<u>2,820,508</u>	<u>4,103,586</u>
Cash and cash equivalents, end of year	<u>\$ 2,271,076</u>	<u>\$ 2,820,508</u>
Supplemental disclosure of cash flow information		
Cash paid during the year for interest	<u>\$ 2,706,591</u>	<u>\$ 1,782,976</u>
Supplemental disclosure of non-cash investing and financing activities		
Accrued distributions to members	<u>\$ 155,942</u>	<u>\$ 439,396</u>
Purchase of members' contribution by issuance of note receivable	<u>\$ 103,185</u>	<u>\$ -</u>

See accompanying notes.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Nature of Business and Significant Accounting Policies

Nature of Business

Strategic Behavioral Health and its subsidiaries (collectively "SBH" or the "Company") provide a variety of services for individuals with psychiatric disorders, including emotional and behavioral disorders. Services provided include but are not limited to therapy, education, nursing and medical services, treatment planning, social skills training and substance abuse counseling.

Strategic Behavioral Health's wholly-owned subsidiaries are as follows:

SBH Wilmington, LLC ("Wilmington") is a 72 bed psychiatric residential treatment facility ("PRTF") and 20 bed acute psychiatric hospital located in Leland, North Carolina. The Hospital is uniquely designed to serve the needs of adolescents ages 12-17 with emotional and behavioral disorders such as ADHD, PTSD, depression, mood, anxiety and oppositional behavioral disorders.

SBH Colorado, LLC ("Peak View") d/b/a Peak View Behavioral Health is a 92 bed acute geriatric psychiatric hospital located in Colorado Springs, Colorado that treats adolescents, adults and seniors with psychiatric disorders.

SBH Raleigh, LLC ("Raleigh") is a 72 bed psychiatric residential and 20 bed acute psychiatric hospital located in Garner, North Carolina. The Hospital is uniquely designed to serve the needs of children and adolescents with emotional and behavioral disorders such as ADHD, PTSD, depression, mood, anxiety and oppositional behavioral disorders.

SBH-Red Rock, LLC ("Red Rock") was formed in 2011 for the purpose of acquiring substantially all the net assets of Red Rock Behavioral Health Hospital in Las Vegas, Nevada. Red Rock Behavioral Health Hospital is a 21 bed acute short-term hospital designed to diagnose and treat the complex mental health and substance abuse problems of people ages 50 and over. The acquisition was completed on January 1, 2012.

SBH-Montevista, LLC ("Montevista") was formed in 2011 for the purpose of acquiring substantially all the net assets of Montevista Hospital in Las Vegas, Nevada. Montevista Hospital is an 90 bed acute psychiatric and chemical dependency hospital providing a full continuum of care for all ages. The land and buildings of Montevista Hospital were acquired on December 30, 2011. The acquisition was completed on January 1, 2012.

SBH Charlotte, LLC ("Charlotte") is a 60 bed psychiatric residential facility in Charlotte, North Carolina, which was opened in the third quarter of 2013. The facility is specifically designed to serve the needs of children/adolescents ages 12-17 with emotional and psychiatric disorders.

SBH El Paso, LLC ("El Paso"), d/b/a Peak Behavioral Health Services, was formed in 2013 for the purpose of acquiring substantially all the net assets of Peak Behavioral Health Services

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

in Santa Teresa, New Mexico. El Paso is a 119 bed psychiatric hospital and residential treatment center specializing in the treatment of children, adolescents, and adults with psychiatric and chemical dependency needs. The acquisition was completed in May 2013.

SBH-College Station, LLC ("College Station") was formed in 2012 and is in the process of building a hospital in College Station, Texas to operate a 72 bed acute psychiatric facility. The Hospital will be specifically designed to serve the needs of children and adults with emotional and psychiatric disorders. The facility was opened in April 2014.

SBH-North Denver, LLC ("Denver"), d/b/a Clear View Behavioral Health was formed in 2013 for the purpose of acquiring land and constructing a new hospital in Denver, Colorado.

SBH-Kingsport, LLC ("Kingsport"), was formed in 2013 for the purpose of acquiring or constructing a hospital in Kingsport, Tennessee. Kingsport has filed for a certificate of need and is awaiting the final determination.

SBH-Mobile, LLC ("Mobile") was formed in 2013 for the purpose of obtaining a certificate of need to operate a psychiatric facility in Mobile, Alabama. The certificate of need was denied and accordingly all related costs were expensed.

The Company's significant accounting policies are summarized below:

Accounting Policy

The Company's policy is to prepare its consolidated financial statements on a modified cash basis of accounting. Except as described below, the Company records amounts due from patients and third-party payors at the time services are rendered and costs and expenses associated with providing services as they are incurred. If an expenditure results in the acquisition of an asset having an estimated useful life which extends substantially beyond the year of acquisition, the expenditure is capitalized and depreciated or amortized over the estimated useful life of the asset. Due to the uncertainty regarding the realization of certain enhanced revenue payments received from governmental payors, these payments are recorded as revenues when the cash is received without considering the potential uncertainties pertaining to any subsequent review by the governmental payors. Additionally, the Company has entered into interest rate swap agreements (see Note 3) with a third party, which are recorded on an accrual basis whereby cash flows are included in interest expense during the period. However, the interest swap agreement is not recorded at fair value at the end of each period as required by accounting principles generally accepted in the United States of America.

Principles of Consolidation

The accompanying consolidated financial statements include SBH and its wholly-owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in the consolidation.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Use of Estimates

The preparation of consolidated financial statements in accordance with the modified cash basis of accounting 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 revenue and expenses during the reporting period.

Actual results could differ from those estimates. The amounts recorded as revenues from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

Cash and Cash Equivalents

For purposes of reporting cash flows, SBH considers all cash accounts and all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents.

Accounts Receivable, Net

SBH reports patient accounts receivable at net realizable value after deduction of allowances for doubtful accounts. Management determines the allowance for doubtful accounts based on historical losses, aging of accounts and current economic and regulatory conditions. On a continuing basis, management analyzes delinquent receivables and, once these receivables are determined to be uncollectible, they are written off through a charge against an existing allowance account or against earnings. For receivables associated with services provided to patients who have third-party coverage, SBH analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts predominately based on the aging of accounts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurances and patients with deductible and copayment balances due for which third-party coverage exists for the part of the bill), SBH records a provision for bad debts based on the age of the accounts. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Company's allowance for doubtful accounts was 16 percent and 10 percent of patient accounts receivable at December 31, 2013 and 2012, respectively. The Company has not changed its charity care policies related to discounts for certain uninsured patients during fiscal years 2013 or 2012.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Inventories

Inventories consist primarily of pharmaceutical supplies and are stated at the lower of cost using the first-in, first-out method, or market.

Prepaid Expenses

Prepaid expenses are amortized over the period of benefit using the straight-line method.

Property and Equipment

Property and equipment is stated at cost. Depreciation is computed using the straight-line method over the useful lives of the assets. Assets under capital leases are recorded at the present value of the future minimum rentals at the lease inception and are amortized over the shorter of the lease term or the useful life of the related asset. Amortization of assets under capital lease obligations is included in depreciation and amortization expense.

Debt Issue Costs

Debt issue costs, which include underwriting, legal and other direct costs related to the issuance of debt, are capitalized and amortized to interest expense over the contractual term of the debt using the effective interest method.

Long-Lived Assets

Long-lived assets, such as property and equipment, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable from the estimated future cash flows expected. The Company will recognize an impairment loss when the carrying amount of a long-lived asset is not expected to be recoverable from its undiscounted cash flows. Such a charge is measured by the amount by which the carrying amount exceeds the estimated fair value of the asset. No such impairment losses have been recognized during 2013 or 2012.

Goodwill

The Company's goodwill was recorded as a result of the Company's business combinations. The Company has recorded these business combinations using the acquisition method of accounting. In 2013, the Company recorded the purchase of SBH-El Paso, which resulted in an addition of \$16,710,662 to previously existing goodwill. During 2012, the Company recorded the acquisitions of SBH-Red Rock and SBH-Montevista which resulted in \$ 28,616,112 of goodwill. The Company tests its recorded goodwill for impairment on an annual basis, or more often if indicators of potential impairment exist. The Company first assesses qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If,

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

after assessing the totality of events or circumstances, the Company determines it is not more-likely-than-not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. Because it was determined that it was not more-likely-than-not that impairment existed, the two-step impairment test was not performed and no impairment loss was recognized during the years ended December 31, 2013 and 2012. Changes to goodwill for 2013 and 2012 are outlined below.

	Balance at 1/1	Additions to Goodwill	Balance at 12/31
2013	\$ 28,616,112	\$ 16,710,662	\$ 45,326,774
2012	\$ -	\$ 28,616,112	\$ 28,616,112

Compensated Absences

SBH employees are granted both vacation and sick leave. Accumulated vacation pay is accrued at the balance sheet date because the employees' right to receive the compensation for the future absences is vested. Sick leave accrues but does not vest; therefore, it is not considered a liability.

Net Revenues

Other than certain enhanced revenue payments received from governmental payors, net revenues are reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered. A summary of the basis of reimbursement with major third-party payors follows:

Medicare

Medicare reimbursement generally is based on the Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS"). Under this methodology, the facility is paid on the basis of a Federal per diem base rate, limited by a specific target amount per discharge, and adjusted annually for such factors as wage index, DRG assignment, rural location and other facility-level adjustments. These annual adjustments are subject to frequent changes and could impact future reimbursement. In addition to the per diem rate, the IPF PPS provides additional payment policies for outlier cases, stop-loss protection, Electroconvulsive Therapy ("ECT") treatments and interrupted stays.

Medicaid

Services rendered to Medicaid beneficiaries are generally reimbursed on a per-diem rate set by each state's division of Medicaid.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

Other

SBH has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to SBH under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

The laws and regulations under which the Medicare and Medicaid programs operate are complex and subject to interpretation and frequent changes. As a part of operating under these programs, there is a possibility that government authorities may review SBH's compliance under these laws and regulations. Such reviews may result in adjustments to program reimbursement previously received and subject SBH to fines and penalties. Although no assurance can be given, management believes that it has complied with the requirements of these programs. Due to the uncertainty regarding the realization of certain enhanced payments received from governmental payors, these payments are recorded as revenues when the cash is received. As of December 31, 2013, cost reports for fiscal years 2010 and forward have not been settled.

Charity Care

SBH provides medical care without charge or at a reduced charge to patients that meet certain criteria. Because SBH does not pursue collection of amounts determined to qualify as charity, these charges are not reported as revenue.

Advertising Costs

Advertising costs are charged to operations as incurred. For the years ended December 31, 2013 and 2012, advertising costs totaled approximately \$305,000 and \$206,000, respectively.

Income Taxes

SBH files a consolidated federal income tax return with its subsidiaries. SBH is structured as a limited liability company and therefore does not incur federal income taxes. The federal taxable earnings are reported by and taxed to the members of SBH individually. SBH also files composite tax returns in several states and makes payments for state income taxes to each of those states on behalf of its members. The state payments are reflected as distributions to members on the accompanying consolidated financial statements. The Company is subject to excise taxes on earnings allocated to the State of Tennessee. The amount of Tennessee excise tax is not considered material and accordingly no deferred or current income taxes are reflected in the accompanying consolidated financial statements.

In accordance with ASC Topic 740, the Company determines if there are any uncertain income tax positions that should be recognized in the Company's financial statements based on tax positions it has taken or is expected to take on a tax return including the entity's status as a pass-through entity. SBH had no significant uncertain tax positions at December 31, 2013 and 2012.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 1. Continued

If interest and penalties are incurred related to uncertain tax positions, such amounts are recognized in income tax expense. Tax periods for all fiscal years 2010 and after remain open to examination by the federal and state taxing jurisdictions to which the Company is subject.

Reclassifications

Certain reclassifications have been made in the 2012 consolidated financial statements to conform with the 2013 presentation. There was no impact in members' equity or changes in members' equity, as previously reported.

Note 2. Long-Term Debt

Long-term debt consists of the following at December 31:

	2013	2012
Credit Facility (See below)		
Term Loan	\$ 55,670,000	\$ -
Construction Loan	6,126,709	-
Revolver Loan	6,800,000	-
Total Credit Facility	68,596,709	-
Other Debt		
Term loan requiring monthly escalating payments ranging from \$21,600 to 29,100 with final balloon payment due on June 30, 2017 (refinanced with Credit Facility)	-	5,386,722
Term loan agreements requiring interest only payments until June 2013 (refinanced with Credit Facility)	-	12,197,190
Term loan requiring monthly escalating payments ranging from \$88,000 to \$108,000 with final balloon payment due on June 30, 2017 (refinanced with Credit Facility)	-	21,444,000
Construction loan of up to \$7.5 million requiring interest only payments until November 2013 (refinanced with Credit Facility)	-	1,400,000

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Continued

	2013	2012
Other Debt - continued		
Revolving loan credit loan of up to \$7 million requiring interest only payments with all outstanding principal due on November 30, 2015 (refinanced with Credit Facility)	\$ -	\$ 2,000,000
Capital lease obligation	3,672	14,686
Total long-term debt	68,600,381	42,442,598
Less current maturities	3,072,422	1,703,039
Long-term debt, less current maturities	<u>\$ 65,527,959</u>	<u>40,739,559</u>

In May 2013, the Company entered into an \$80 million Credit Facility (the "Credit Facility") with a syndicated group of lenders with a maturity date of May 2018. The Credit Facility consists of an initial Term Loan of \$57 million, a Construction Loan (the "Construction Loan") of up to \$7.5 million and a Revolving Line of Credit (the "Revolver Loan") of up to \$15.5 million. The purpose of the Credit Facility was to fund the El Paso acquisition, as well as to refinance substantially all existing debt. The terms of the Credit Facility are as follows:

Monthly Principal Payments	Term Loan	Construction Loan	Total
From January 31, 2014 through December 31, 2016	\$ 237,500	\$ -	\$ 237,500
From June 30, 2014 through December 31, 2016	\$ -	\$ 31,250	\$ 31,250
From January 31, 2017 through April 30, 2018	\$ 285,000	\$ 37,500	\$ 322,500
Final payment May 20, 2018	\$ 42,560,000	\$ 4,557,959	\$ 47,117,959

The Revolver Loan requires monthly interest only payments through maturity with all principal due at the maturity date of May 20, 2018.

The interest rates on all the loans under the Credit Facility are based on the Funded Debt to EBITDA Ratio as follows:

Funded Debt to EBITDA Ratio	Spread
Less than 2.50	30-Day LIBOR + 275 basis points
Greater than 2.50 but less 3.50	30-Day LIBOR + 300 basis points
Greater than or equal to 3.50	30-Day LIBOR + 350 basis points

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 2. Continued

The interest rate at December 31, 2013 was at 3.75 percent.

The previous debt outstanding at December 31, 2012 required interest on the loans at a variable rate equal to the 30-Day LIBOR plus a certain amount of basis points beginning at 350 (3.114 percent at December 31, 2012).

The Credit Facility is secured by substantially all of the assets of the Company.

The terms of the Credit Facility described above requires certain affirmative and negative debt covenants including the maintenance of a minimum fixed charge coverage ratio and a maximum funded debt to EBITDA ratio. At December 31, 2013 and 2012, SBH was in compliance with all required covenants.

The maturities of long-term debt are as follows:

Year Ending December 31,	Amount
2014	\$ 3,072,422
2015	3,225,000
2016	3,225,000
2017	3,870,000
2018	55,207,959
Total	<u>\$ 68,600,381</u>

Note 3. Interest Rate Swaps

The Company has entered into various interest rate swap agreements to manage interest costs and risks associated with changes in interest rates. These agreements effectively convert underlying variable-rate debt based on the 30-Day LIBOR to fixed-rate debt through the exchange of fixed and floating interest payment obligations without the exchange of underlying principal amounts.

At December 1, 2013 and 2012, the following interest rate swap agreements were in effect:

	Description	Notional Value	Maturity	Pay Index	Receive Index	Fair Value
<u>Swap 1</u>						
December 31, 2013	Fixed payer	\$ 5,069,966	June 2017	4.29%	30-Day LIBOR	\$ (530,785)
December 31, 2012	Fixed payer	5,354,366	June 2017	4.29%	30-Day LIBOR	(782,553)
<u>Swap 2</u>						
December 31, 2013	Fixed payer	20,340,000	June 2017	1.06%	30-Day LIBOR	(67,942)
December 31, 2012	Fixed payer	21,444,000	June 2017	1.06%	30-Day LIBOR	(382,300)

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 3. Continued

	Description	Notional Value	Maturity	Pay Index	Receive Index	Fair Value
<u>Swap 3</u>						
December 31, 2013	Fixed payer	\$ 6,362,000	June 2017	.87%	30-Day LIBOR	\$ 19,585
<u>Swap 4</u>						
December 31, 2013	Fixed payer	5,581,500	June 2017	.87%	30-Day LIBOR	17,162
<u>Swap 5</u>						
December 31, 2013	Fixed payer	19,931,973	June 2017	.90%	30-Day LIBOR	7,790
<u>Swap 6</u>						
December 31, 2013	Fixed payer	45,410,000	May 2018	2.96%	30-Day LIBOR	59,507
					Fair value 2013	\$ (494,683)
					Fair value 2012	\$ (1,164,853)

Swap 6 is a forward interest rate swap that becomes effective on July 1, 2017.

As a result of the interest rate swap agreements, interest expense increased by \$343,003 and \$388,381 in relation to the required debt service for the years ended December 31, 2013 and 2012, respectively.

Note 4. Property and Equipment

A summary of property and equipment follows:

	December 31,	
	2013	2012
Land and improvements	\$ 8,739,753	\$ 7,046,476
Building and improvements	45,839,068	36,139,060
Fixed and major moveable equipment	7,124,183	4,489,785
	61,703,004	47,675,321
Less accumulated depreciation and amortization	(4,331,553)	(2,181,981)
	57,371,451	45,493,340
Construction in progress	11,723,061	1,168,576
Property and equipment, net	\$ 69,094,512	\$ 46,661,916

Depreciation expense related to these assets for the years ended December 31, 2013 and 2012 amounted to \$2,169,598 and \$1,211,918, respectively. The amount of interest capitalized by the Company was \$223,277 and \$276,459 for the years ended December 31, 2013 and 2012, respectively.

At December 31, 2013, the Company had outstanding construction commitments related to construction in progress of \$8,152,606.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 5. Other Assets

Other assets at December 31, 2013 and 2012 consisted of the following:

	2013	2012
Debt issue costs, net of accumulated amortization of \$313,677 and \$110,181 at December 31, 2013 and 2012, respectively	\$ 1,229,820	\$ 950,442
Other	32,557	-
Deposits	208,243	130,079
	\$ 1,470,620	\$ 1,080,521

Note 6. Leases

SBH leases certain property and equipment from third parties and related parties under long-term operating leases. Total rental expense for all operating leases for the years ended December 31, 2013 and 2012 was \$967,683 and \$880,575, respectively. Minimum future rental payments under non-cancelable operating leases having remaining terms in excess of one year as of December 31, 2013 are as follows:

Year Ending December 31,	Amount
2014	\$ 601,885
2015	618,165
2016	481,709
2017	186,367
2018	188,434
Thereafter	111,625
Total	\$ 2,188,185

Note 7. Patient Accounts Receivable and Net Patient Service Revenue

Patient Accounts Receivable, Net

SBH grants credit without collateral to its patients. The percentage mix of receivables from patients and third-party payors is as follows:

	December 31,	
	2013	2012
Medicare	20%	32%
Medicaid	39	20
Commercial	35	41
Self Pay	6	7
Total	100%	100%

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 7. Continued

A summary of the activity in the allowance for doubtful accounts for 2013 and 2012 is as follows:

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2013	\$ 915,540	\$ 3,849,410	\$ (2,220,783)	\$ 2,544,167

	Balance at Beginning of Year	Additions to Allowance	Accounts Written Off, Net of Recoveries	Balance End of Year
Allowance for doubtful accounts year ended December 31, 2012	\$ 264,197	\$ 748,305	\$ (96,962)	\$ 915,540

A summary of net revenue, net of the provision for bad debts, for patient services rendered for the years ended December 31, 2013 and 2012 is as follows:

	2013		2012	
	Amount	Percentage	Amount	Percentage
Medicare	\$ 15,839,812	20%	\$ 13,402,841	27%
Medicaid	29,150,783	36%	15,748,639	32%
Commercial	33,034,894	41%	17,126,526	34%
Self Pay	788,139	1%	383,151	1%
Other	1,678,759	2%	3,221,221	6%
	\$ 80,492,387	100%	\$ 49,882,378	100%

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Year Ended December 31, 2013		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	\$ 83,515,967	\$ 825,830	\$ 84,341,797

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 7. Continued

	Year Ended December 31, 2012		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	\$ 50,241,784	\$ 388,899	\$ 50,630,683

Note 8. Charity Care

The Company maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The direct and indirect cost, which includes all operating expenses excluding the provision for bad debts, associated with these services cannot be identified to specific charity care patients. Therefore, management estimated the costs of these services by calculating a ratio of cost to gross charges and multiplying that ratio by the gross charges associated with providing care to charity patients. The estimated direct and indirect cost incurred is approximately \$485,000 and \$739,000 for the years ended December 31, 2013 and 2012, respectively.

Note 9. Insurance Programs

SBH purchases professional and general liability insurance to cover medical malpractice claims. Management believes that any claims would be substantially covered under its insurance program and would not have a significant effect on the consolidated financial statements. Nevertheless, the future assertion of claims for occurrences prior to year-end is possible and may occur, although not anticipated.

Note 10. Related Party Transactions

Dobbs Management Service, LLC ("Dobbs") is a related party entity due to common ownership by certain members of SBH. SBH's business formation agreement requires a base management fee to Dobbs in an amount not to exceed \$5,000 per month. Management fees incurred to Dobbs were \$60,000 for each of the years ended December 31, 2013 and 2012.

The business formation agreement also requires that guaranteed payments be made to two of SBH's members. For the years ended December 31, 2013 and 2012, the amounts of guaranteed payments totaled \$418,636 and \$383,375, respectively, and are included in salaries and benefits on the accompanying consolidated financial statements.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 10. Continued

Additionally, the business formation agreement requires that an incentive fee equal to 2 and 5 percent of net income be paid to both a member of SBH and Dobbs, respectively. The incentive fees for the years ended December 31, 2013 and 2012 were \$754,517 and \$709,176, respectively. Accrued incentive fees at December 31, 2013 and 2012 were \$58,868 and \$58,505, respectively.

SBH has declared certain distributions payable to its members as of December 31, 2013 and 2012 related to income tax distributions. Total accrued distributions to members as of December 31, 2013 and 2012 were \$155,942 and \$439,396, respectively.

The Company allows members from time to time to transact equity transactions in the form of secured promissory notes. At December 31, 2013 and 2012 outstanding amounts receivable from members were \$161,878 and \$76,616, respectively. Interest is charged at a variable rate with the principal to be paid at dates in the future. The Company received \$12,923 and \$5,000 of principal payments related to the notes receivable during 2013 and 2012, respectively. Note receivable balances due from members are presented as a component of members' equity on the accompanying consolidated financial statements.

The Company purchases property, casualty, and malpractice insurance coverage from a company which is owned by Dobbs. During 2013 and 2012, the Company paid insurance premiums of approximately \$1,500,000 and \$985,000, respectively to this party.

Note 11. Employee Benefits

SBH participates in a multi-employer defined contribution 401(k) plan sponsored by Dobbs for its eligible employees. Contributions by the Company to the plan for the years ended December 31, 2013 and 2012 were \$249,221 and \$139,399, respectively.

SBH also provides health insurance benefits to its eligible employees. Health insurance benefits provided were \$2,972,148 and \$1,834,556 for the years ended December 31, 2013 and 2012, respectively.

Note 12. Risks and Uncertainties

SBH is involved in litigation in the normal course of business. Management is of the opinion that likelihood of any financial impact to SBH would be minimal and would be covered by insurance.

The amounts of certain enhanced revenues received from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

SBH maintains cash deposits that are in excess of FDIC insurance limits. The Company has not experienced any losses as a result of this concentration.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES
Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 13. Acquisition

On May 19, 2013, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets and assumption of certain liabilities of Peak Behavioral Hospital. The Company's acquisition was based on management's belief that the Santa Teresa, New Mexico location is complementary to the Company's existing business and provides a base for further growth. The total original purchase price was \$24,000,000.

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets, and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

Assets	
Accounts receivable	\$ 2,389,688
Inventory	20,669
Prepaid expenses and other assets	24,927
Property and equipment	5,988,588
Goodwill	16,710,662
Assets acquired	<u>25,134,534</u>
Liabilities	
Accounts payable	85,309
Accrued expenses	285,048
Total liabilities	<u>370,357</u>
Net assets acquired	<u>\$ 24,764,177</u>

The difference between the original consideration paid of \$24,000,000 and assets acquired of \$24,764,177 is \$764,177 and represents a subsequent working capital adjustment paid to UHS.

On December 30, 2011, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets of Montevista Hospital and Red Rock Behavioral Health Hospital. This transaction was not completed until January 1, 2012. The Company's acquisition was based on management's belief that the Las Vegas locations are very complementary to the Company's existing business and provides a base for further growth. The total original purchase price was \$43,944,726. As of December 31, 2011, the consideration was remitted by the Company in the form of cash to UHS in the amount \$21,444,726 with the additional consideration of \$22,500,000 provided to UHS from the proceeds of new debt with a financial institution.

STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

Note 13. Continued

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

Assets	
Accounts receivable	\$ 3,200,647
Inventory	45,056
Prepaid expenses	277,864
Property and equipment	12,406,541
Goodwill	28,616,112
Deposits	37,692
Total assets	<u>44,583,912</u>
Liabilities	
Accounts payable	209,874
Accrued expenses	579,183
Capital lease obligation	45,630
Total liabilities	<u>834,687</u>
Net assets acquired	<u>\$ 43,749,225</u>

The difference between the original consideration paid of \$43,944,726 and net assets acquired of \$43,749,225 is \$195,501 and represents a subsequent working capital adjustment received from UHS to the final purchase price.

During 2013 and 2012, the Company recorded expenses of approximately \$620,000 and \$51,000, respectively, related to costs incurred in this and other potential acquisitions. The acquisition costs were primarily related to legal and professional fees and other costs incurred in performing due diligence.

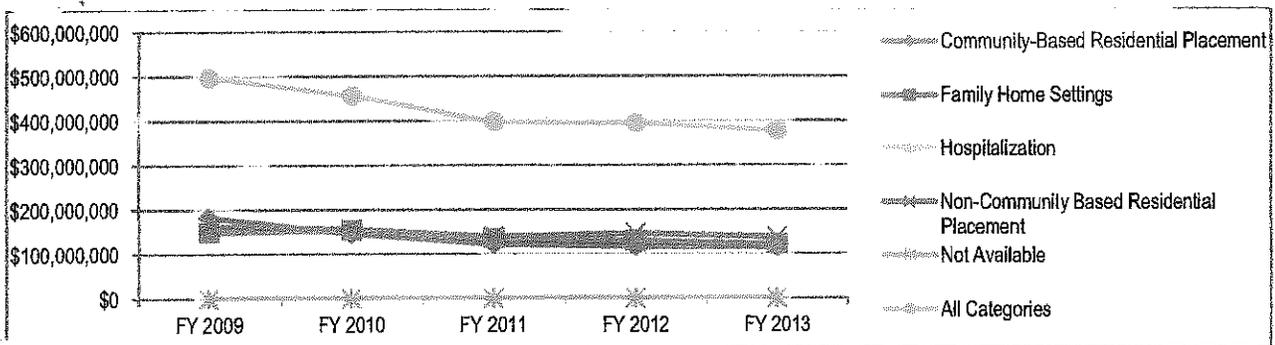
Note 14. Subsequent Events

SBH has evaluated, for consideration of recognition or disclosure, subsequent events that have occurred through May 22, 2014, the date the consolidated financial statements were available to be issued and has determined that no significant events have occurred subsequent to December 31, 2013 but prior to May 22, 2014 that would have a material impact on its consolidated financial statements.

Exhibit 12

FIGURES

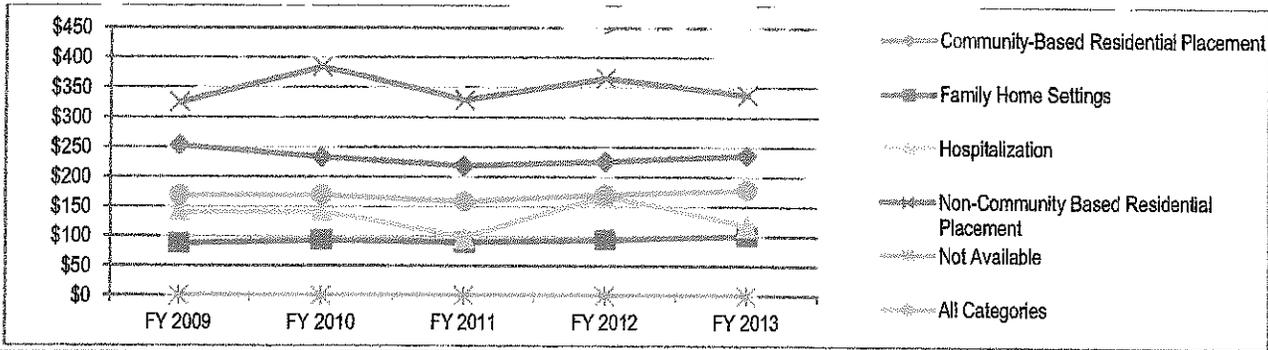
Figure 1



Statewide Total Costs

Category	FY2009	FY2010	FY2011	FY2012	FY2013	Average Change	Last Year Change
Community-Based Residential Placement	\$183,469,850	\$145,760,440	\$122,210,854	\$117,152,599	\$115,749,751	-10.5%	-1.2%
Family Home Settings	\$150,052,028	\$154,528,388	\$136,152,905	\$130,233,996	\$122,415,468	-4.8%	-6.0%
Hospitalization	\$110,292	\$97,064	\$28,977	\$14,946	\$41,220	11.3%	175.8%
Non-Community-Based Residential Placement	\$163,382,867	\$156,486,635	\$139,430,318	\$147,085,835	\$138,213,891	-3.9%	-6.0%
Not Available	\$0	\$0	\$0	\$0	\$0	NA	NA
All Categories	\$497,015,037	\$456,872,528	\$397,823,054	\$394,487,375	\$376,420,330	-6.6%	-4.6%

Figure 2



Statewide Costs Per Bed-Day

Category	FY2009	FY2010	FY2011	FY2012	FY2013	Average Change	Last Year Change
Community-Based Residential Placement	\$253	\$233	\$219	\$226	\$236	-1.5%	4.5%
Family Home Settings	\$89	\$94	\$90	\$95	\$102	3.6%	6.9%
Hospitalization	\$140	\$141	\$99	\$168	\$118	2.9%	-29.5%
Non-Community-Based Residential Placement	\$325	\$385	\$329	\$366	\$338	1.8%	-7.6%
Not Available	NA	NA	NA	NA	NA	NA	NA
All Categories	\$170	\$171	\$160	\$172	\$179	1.4%	3.9%

Figure 3

ADAA	DDA	MHA	MSDE	DJS	DHR	Placing Agency	Family Home Placement	Community-Based Placement	Non-Community-Based Placement	Hospitalization Placement
					38	Adoptive Care				
				5	1,204	Foster Care				
					363	Formal Relative (Kinship) Care				
					401	Restricted Relative (Kinship) Care				
				66	1,693	Treatment Foster Care				
					338	Living Arrangement - Family Home				
				18	213	Independent Living Programs				
	22			236	750	Residential Child Care Program				
	81					Community Supported Living Arrangement (CSLA)				
					69	Living Arrangement - Community-Based				
				25		Diagnostic Evaluation Treatment Program				
				185		Juvenile Detention and Commitment Centers				
				69		Non-Secure/Non-RTC				
			68			Residential Educational Facilities				
		401		179	168	Residential Treatment Centers				
175				279		Substance Abuse and Addiction Programs (ASAM)				
					100	Living Arrangement - Non-Community-Based				
					6	In-Patient Private				
				9	16	Psychiatric Hospitalization				

State Agency Placement Categories, Placement Totals on 1/31/2013

Figure 4

Maryland State Placement Trends by Category

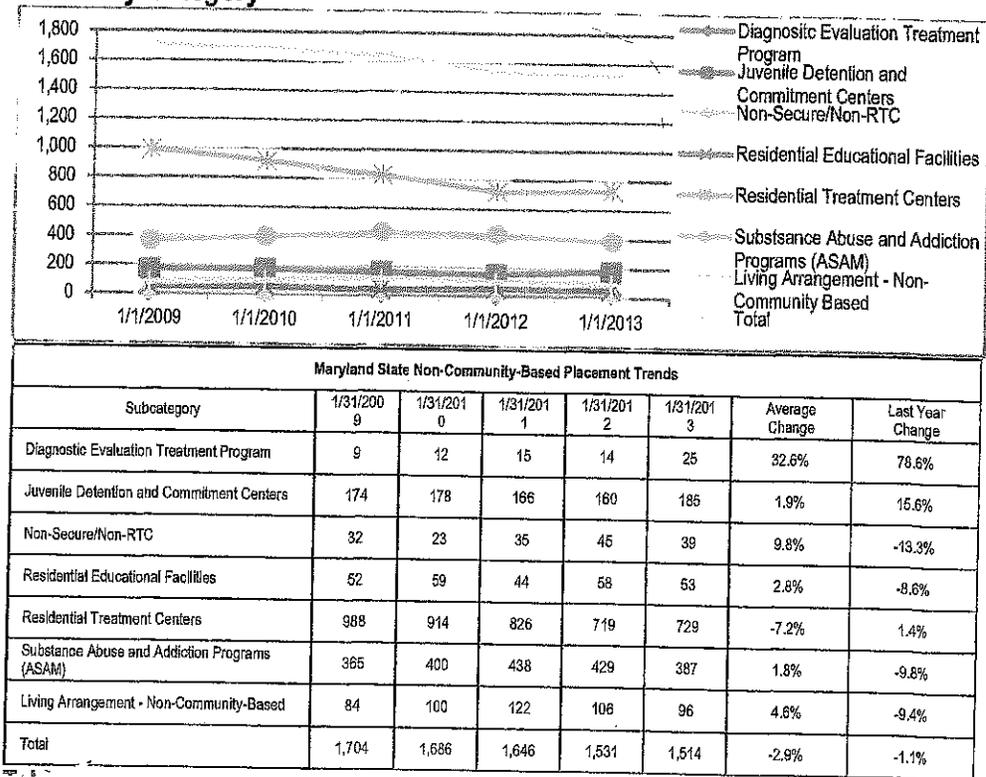
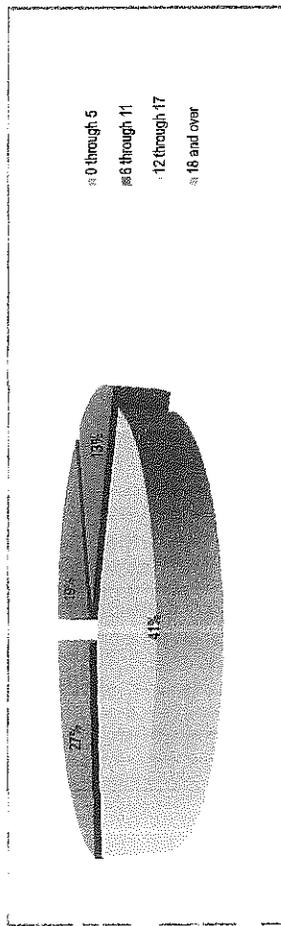


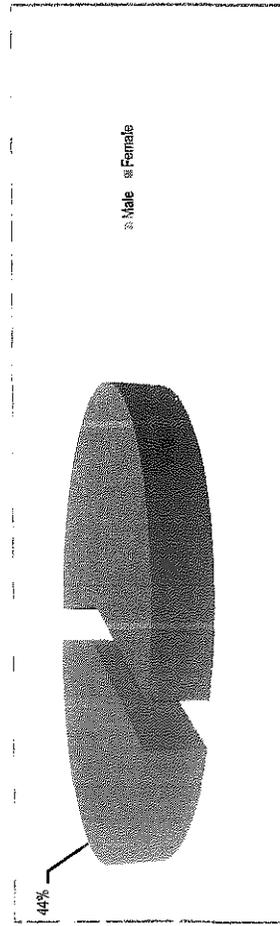
Figure 5
STATEWIDE Addendum
Statewide Demographic Comparisons

Age



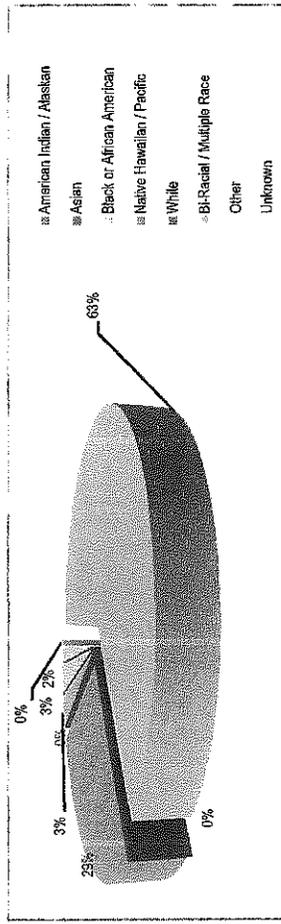
Age	Maryland State Age Trends					Average Change	Last Year Change
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013		
0 through 5	2,122	1,953	1,647	1,616	1,481	-8.5%	-8.4%
6 through 11	1,842	1,562	1,308	1,116	1,054	-13.4%	-7.3%
12 through 17	4,703	4,481	3,972	3,639	3,201	-9.1%	-12.0%
18 and over	2,107	2,364	2,454	2,304	2,107	0.3%	-8.6%
Total	10,774	10,360	9,379	8,675	7,823	-7.7%	-9.5%

Gender



Gender	Maryland State Gender Trends					Average Change	Last Year Change
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013		
Male	6,085	5,766	5,285	4,815	4,370	-7.5%	-9.2%
Female	4,689	4,593	4,093	3,859	3,453	-7.3%	-10.5%

Race



Race	Maryland State Race Trends							Average Change	Last Year Change
	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013				
American Indian / Alaskan	13	10	7	6	6	6	-16.8%	0.0%	
Asian	33	33	33	30	32	32	-0.6%	6.7%	
Black or African American	7,482	7,131	6,288	5,643	4,949	4,949	-8.6%	-12.3%	
Native Hawaiian / Pacific	3	5	5	5	3	3	6.7%	-40.0%	
White	2,602	2,489	2,383	2,388	2,247	2,247	-3.6%	-5.9%	
Bi-Racial / Multiple Race	302	309	279	267	236	236	-5.8%	-11.6%	
Other	223	252	238	227	220	220	-0.1%	-3.1%	
Unknown	116	131	145	109	130	130	4.5%	19.3%	
Total	10,774	10,360	9,379	8,675	7,823	7,823	-7.7%	-9.5%	

STATEWIDE Addendum Statewide OOS One-Day Census Totals

Figure 6

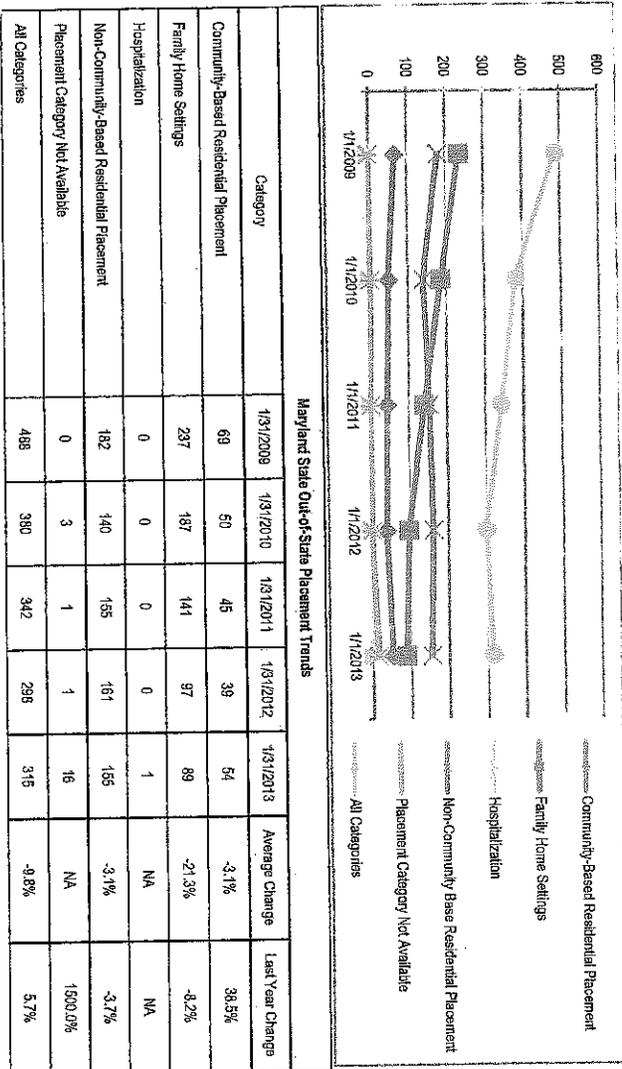
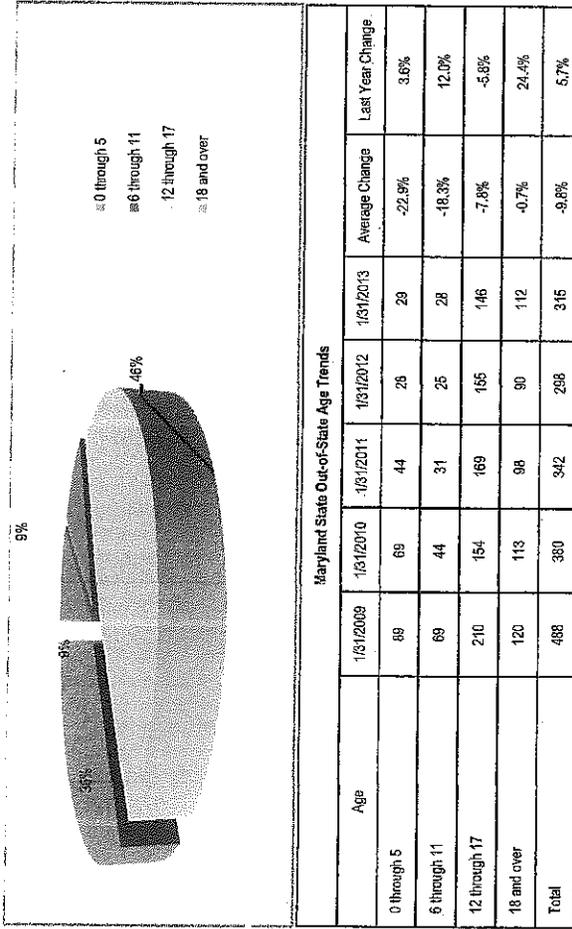


Figure 7
STATEWIDE ADDENDUM
Stafewide OOS Demographic Comparisons

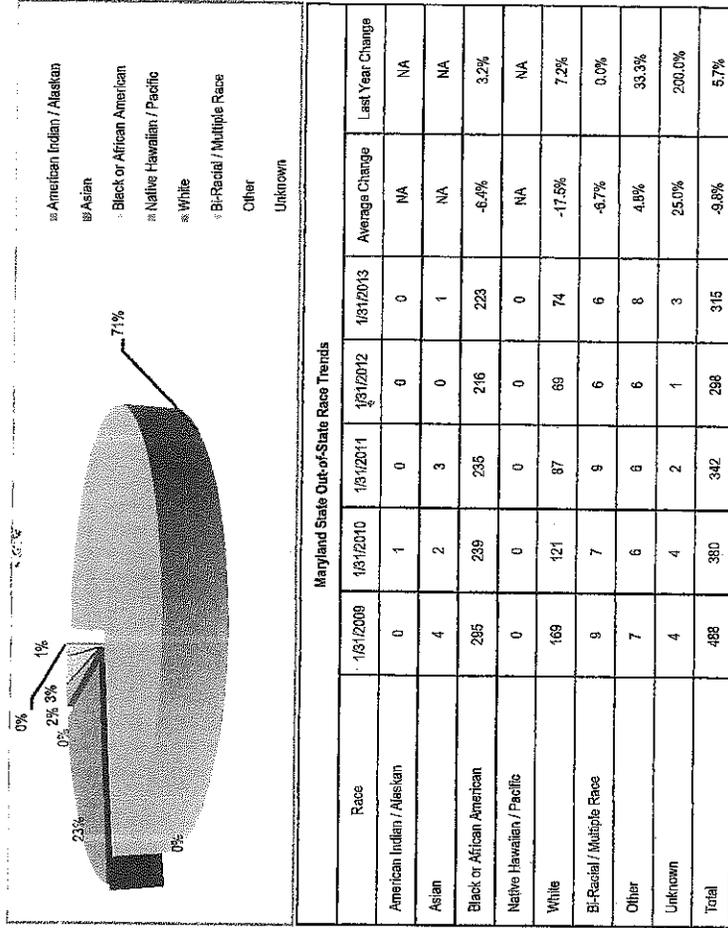
Age



Maryland State Out-of-State Age Trends

Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
0 through 5	69	66	44	29	29	-22.9%	3.6%
6 through 11	69	44	31	25	28	-18.3%	12.0%
12 through 17	210	154	169	165	146	-7.8%	-5.8%
18 and over	120	113	98	90	112	-0.7%	24.4%
Total	488	380	342	298	315	-9.8%	5.7%

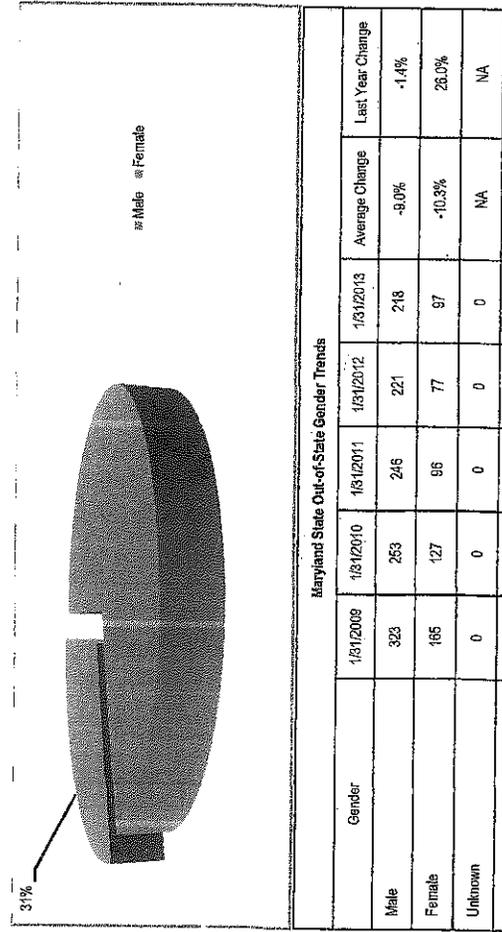
Race



Maryland State Out-of-State Race Trends

Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
American Indian / Alaskan	0	1	0	0	0	NA	NA
Asian	4	2	3	0	1	NA	NA
Black or African American	285	239	235	216	223	-6.4%	3.2%
Native Hawaiian / Pacific	0	0	0	0	0	NA	NA
White	169	121	87	69	74	-17.5%	7.2%
BI-Racial / Multiple Race	9	7	9	6	6	-8.7%	0.0%
Other	7	6	6	6	8	4.8%	33.3%
Unknown	4	4	2	1	3	25.0%	200.0%
Total	488	380	342	298	315	-9.8%	5.7%

Gender



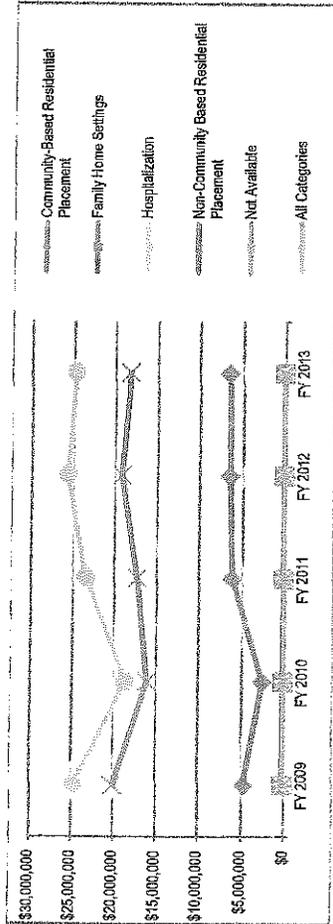
Maryland State Out-of-State Gender Trends

Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
Male	323	253	246	221	218	-9.0%	-1.4%
Female	165	127	66	77	97	-10.3%	26.0%
Unknown	0	0	0	0	0	NA	NA

Figure 8

STATEWIDE AGENDUM
Statewide OOS Cost Comparisons

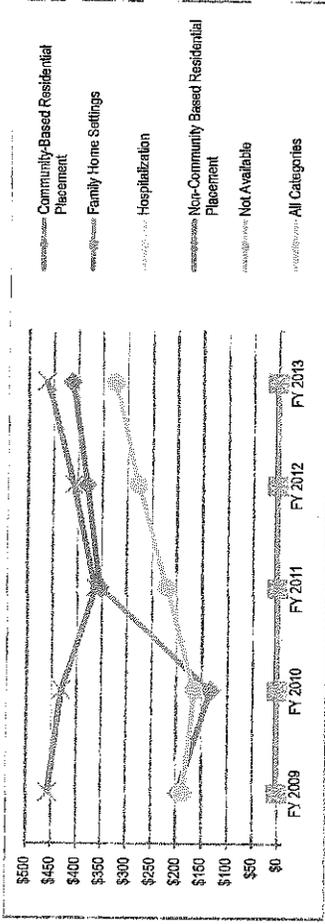
Total Costs



Maryland State Out-of-State Cost Trends

Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	Average Change	Last Year Change
Community-Based Residential Placement	\$4,677,421	\$2,529,376	\$6,167,030	\$6,481,015	\$6,545,427	26.0%	1.0%
Family Home Settings	\$142,750	\$117,590	\$87,050	\$86,818	\$55,033	-20.7%	-14.9%
Hospitalization	\$0	\$0	\$0	\$0	\$0	NA	NA
Non-Community Based Residential Placement	\$20,004,652	\$16,008,362	\$17,242,719	\$19,199,909	\$18,157,431	-1.6%	-5.1%
Not Available	\$0	\$0	\$0	\$0	\$0	NA	NA
All Categories	\$24,825,023	\$23,496,009	\$25,665,736	\$24,758,892	\$24,758,892	1.7%	-3.6%

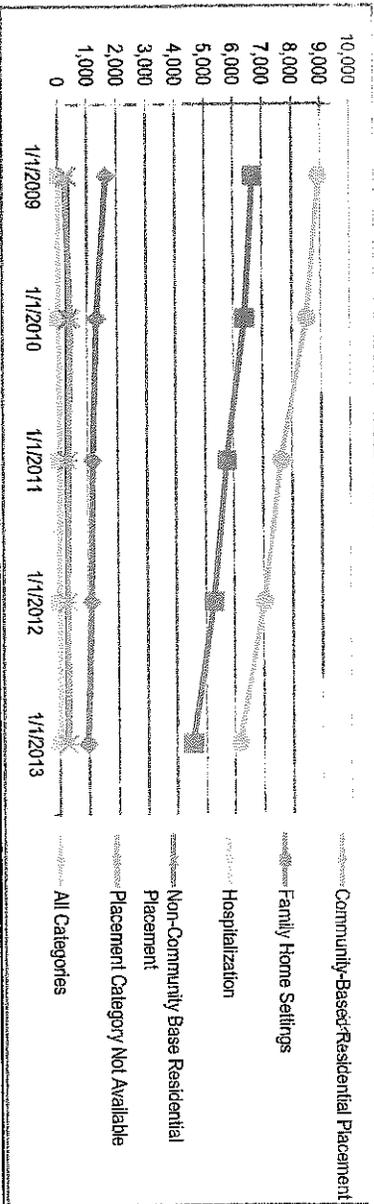
Per Bed-Day



Maryland State Out-of-State Costs Per Bed-Day

Category	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	Average Change	Last Year Change
Community-Based Residential Placement	\$165	\$165	\$165	\$278	\$325	37.3%	8.2%
Family Home Settings	\$2	\$2	\$2	\$2	\$3	5.5%	15.2%
Hospitalization	\$0	\$0	\$0	\$0	\$0	NA	NA
Non-Community Based Residential Placement	\$165	\$431	\$363	\$408	\$463	1.2%	13.3%
Not Available	\$0	\$0	\$0	\$0	\$0	NA	NA
All Categories	\$165	\$165	\$220	\$278	\$325	16.3%	16.9%

Figure 9



DHR Placement Trends							
Category	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
Community-Based Residential Placement	1,849	1,321	1,170	1,116	978	-12.1%	-12.4%
Family Home Settings	6,672	6,397	5,765	5,286	4,548	-9.1%	-14.0%
Hospitalization	21	23	38	11	22	25.9%	100.0%
Non-Community-Based Residential Placement	335	399	306	299	279	-4.4%	-6.7%
Placement Category Not Available	251	435	336	302	324	11.9%	7.3%
All Categories	8,928	8,515	7,615	7,014	6,151	-8.8%	-12.3%

Figure 10

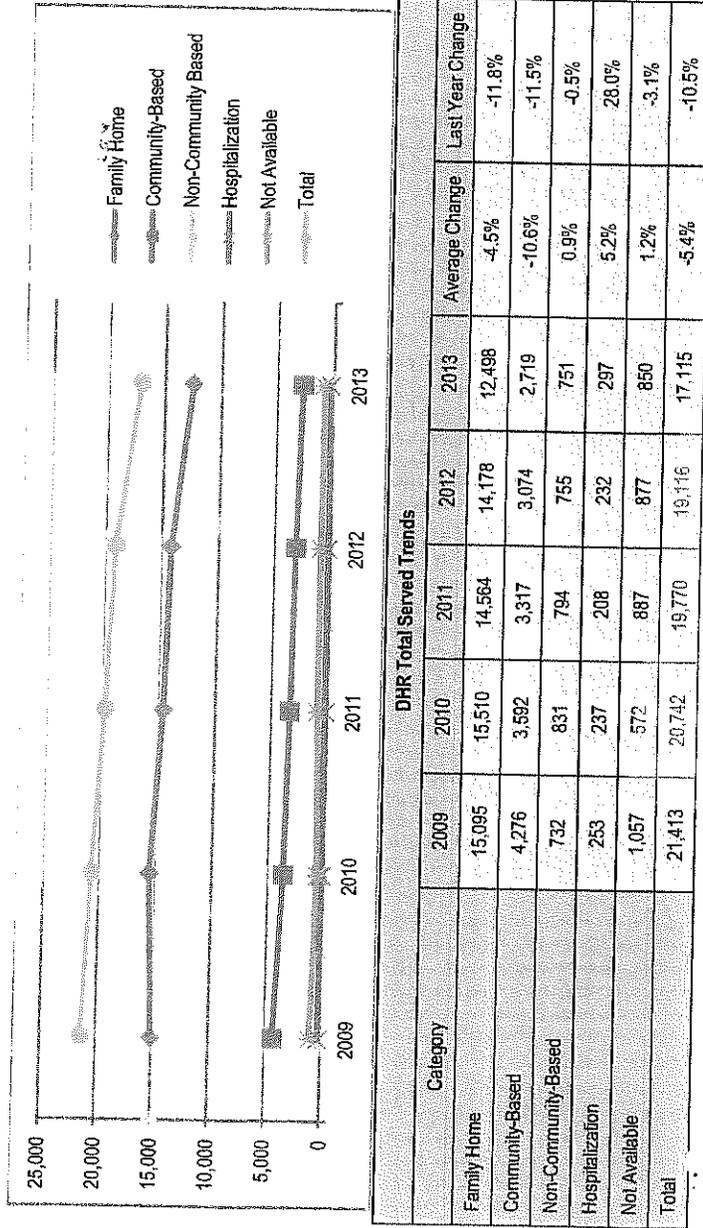
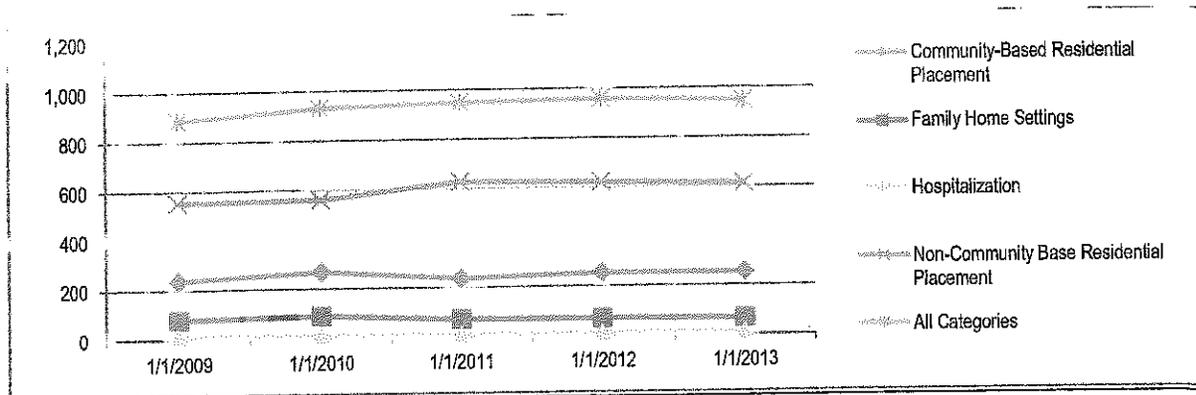


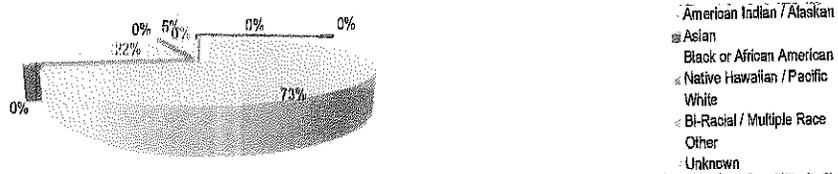
Figure 11



DJS Placement Trends							
Category	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
Community-Based Residential Placement	238	268	237	254	254	2.1%	0.0%
Family Home Settings	83	93	75	73	71	-3.2%	-2.7%
Hospitalization	8	8	5	7	9	7.8%	28.6%
Non-Community-Based Residential Placement	556	562	630	623	614	2.7%	-1.4%
Placement Category Not Available	0	0	0	0	0	NA	NA
All Categories	885	931	947	957	948	1.8%	-0.9%

Figure 12

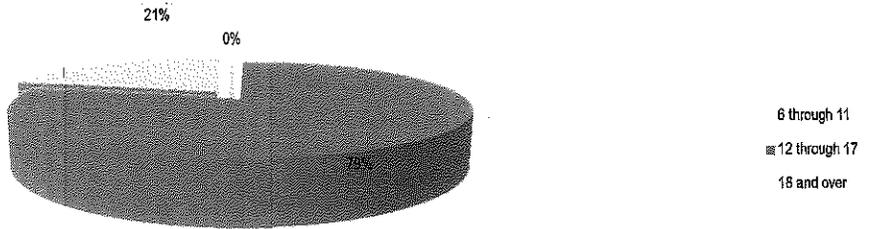
DJS Addendum
Subcategory Totals Demographic Comparisons
Race



DJS Non-Community-Based Race Trends							
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
American Indian / Alaskan	1	1	0	0	0	NA	NA
Asian	2	1	3	0	2	NA	NA
Black or African American	383	398	456	450	450	4.3%	0.0%
Native Hawaiian / Pacific	0	0	0	0	0	NA	NA
White	154	132	143	151	131	-3.4%	-13.2%
Bi-Racial / Multiple Race	0	0	0	0	0	NA	NA
Other	14	25	24	22	31	26.8%	40.9%
Unknown	2	5	4	0	0	NA	NA
Total	556	562	630	623	614	2.7%	-1.4%

Figure 13

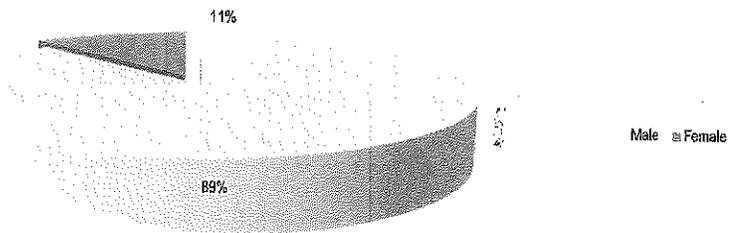
DJS Addendum
Subcategory Totals Demographic Comparisons
Age



DJS Non-Community-Based Age Trends							
Age	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
0 through 5	0	0	0	0	0	NA	NA
6 through 11	0	1	1	1	3	NA	200.0%
12 through 17	442	428	486	488	482	2.3%	-1.2%
18 and over	114	133	163	134	129	4.4%	-3.7%
Total	556	562	630	623	614	2.7%	-1.4%

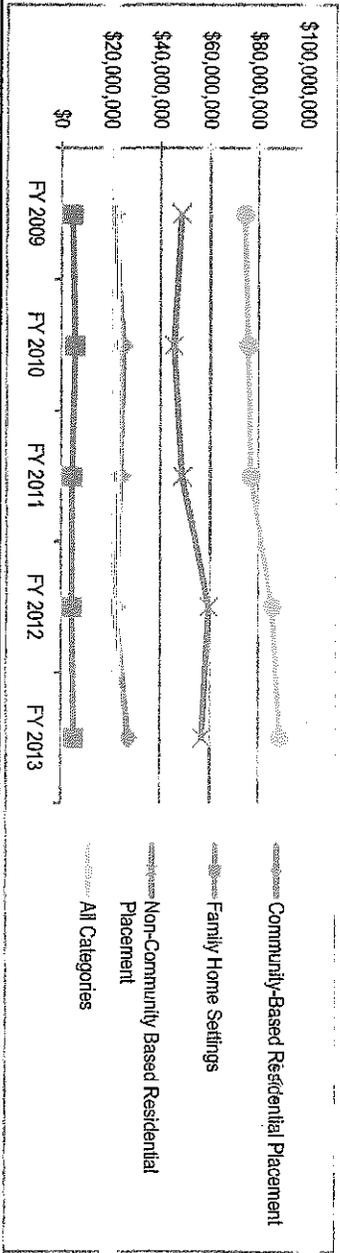
Figure 14

DJS Addendum
Subcategory Totals Demographic Comparisons
Gender



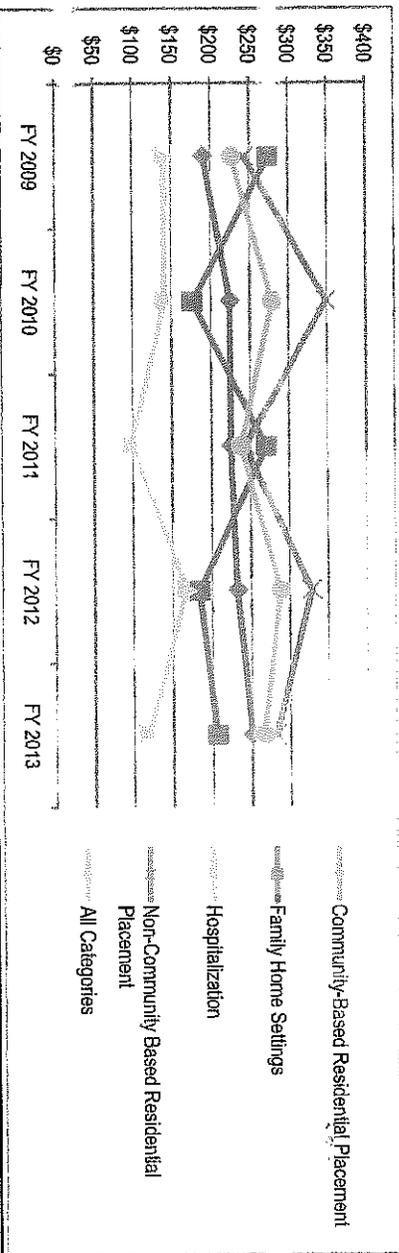
DJS Non-Community-Based Gender Trends							
Gender	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
Male	502	506	575	565	545	2.3%	-3.5%
Female	54	56	55	58	69	6.6%	19.0%
Unknown	0	0	0	0	0	NA	NA
Total	556	562	630	623	614	2.7%	-1.4%

Figure 15



Category	FY2009	FY2010	FY2011	FY2012	FY2013	Average Change	Last Year Change
Community-Based Residential Placement	\$21,242,760	\$24,592,016	\$23,676,804	\$21,634,051	\$26,725,210	6.7%	23.5%
Family Home Settings	\$4,679,628	\$5,717,155	\$4,575,954	\$4,517,994	\$5,329,639	4.7%	18.0%
Hospitalization	\$110,292	\$97,084	\$28,977	\$14,946	\$41,220	11.3%	175.8%
Non-Community-Based Residential Placement	\$48,362,284	\$45,458,947	\$48,695,167	\$59,475,243	\$56,581,033	4.6%	-4.9%
Not Available	\$0	\$0	\$0	\$0	\$0	NA	NA
All Categories	\$74,394,864	\$75,865,182	\$76,976,902	\$85,642,234	\$88,677,102	4.8%	3.5%

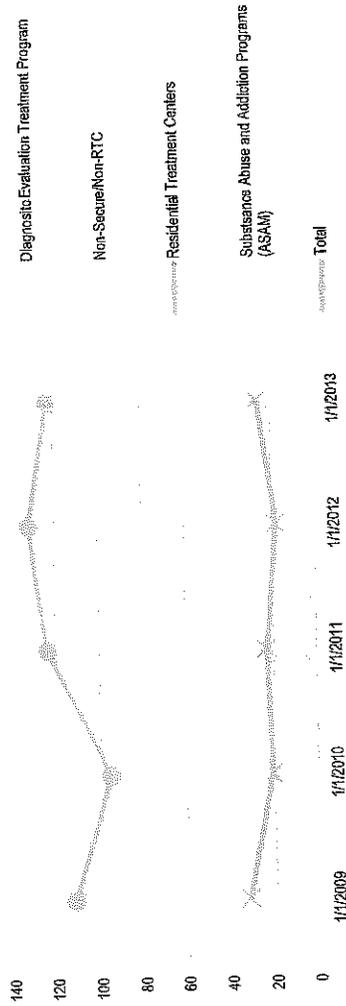
Figure 16



Category	FY2009	FY2010	FY2011	FY2012	FY2013	Average Change	Last Year Change
Community-Based Residential Placement	\$191	\$225	\$225	\$233	\$251	7.3%	7.7%
Family Home Settings	\$274	\$177	\$271	\$184	\$206	-0.7%	11.6%
Hospitalization	\$140	\$141	\$99	\$168	\$118	2.9%	-29.5%
Non-Community-Based Residential Placement	\$244	\$349	\$243	\$329	\$281	8.5%	-14.5%
Not Available	NA	NA	NA	NA	NA	NA	NA
All Categories	\$227	\$279	\$239	\$287	\$266	5.3%	-7.5%

Figure 17

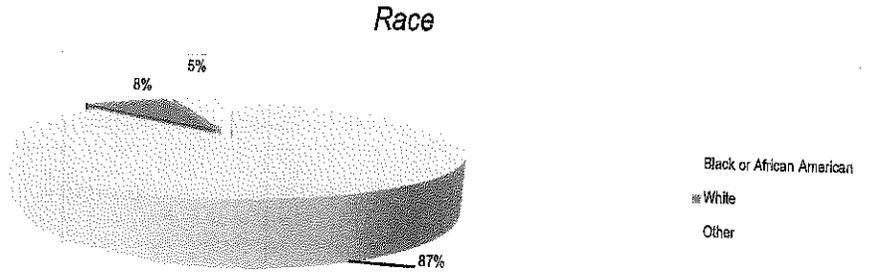
DJS Addendum Subcategory OOS One-Day Census Totals



DJS Out-of-State Non-Community-Based Trends						
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Last Year Change
Diagnostic Evaluation Treatment Program	1	2	5	0	0	NA
Juvenile Detention and Commitment Centers	0	0	0	0	0	NA
Non-Secure/Non-RTC	28	19	28	38	30	7.5%
Residential Educational Facilities	0	0	0	0	0	NA
Residential Treatment Centers	32	21	23	18	26	-0.5%
Substance Abuse and Addiction Programs (ASAM)	51	53	68	76	67	8.0%
Living Arrangement - Non-Community-Based	0	0	0	0	0	NA
Total	112	95	124	132	123	3.7%

Figure 18

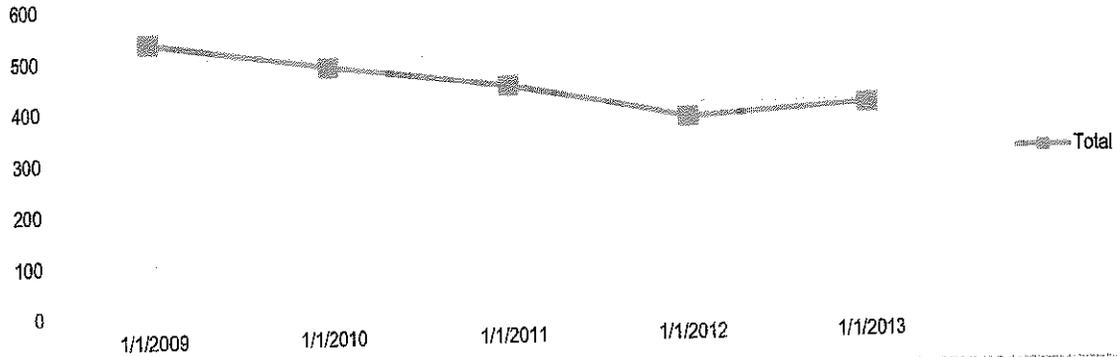
DJS Addendum
Subcategory OOS Demographic Comparisons



DJS Out-of-State Non-Community-Based Race Trends							
Race	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
American Indian / Alaskan	0	1	0	0	0	NA	NA
Asian	2	0	1	0	0	NA	NA
Black or African American	92	78	104	119	107	5.6%	-10.1%
Native Hawaiian / Pacific	0	0	0	0	0	NA	NA
White	17	12	12	8	10	-9.4%	25.0%
Bi-Racial / Multiple Race	0	0	0	0	0	NA	NA
Other	1	4	6	5	6	88.3%	20.0%
Unknown	0	0	1	0	0	NA	NA
Total	112	95	124	132	123	3.7%	-6.8%

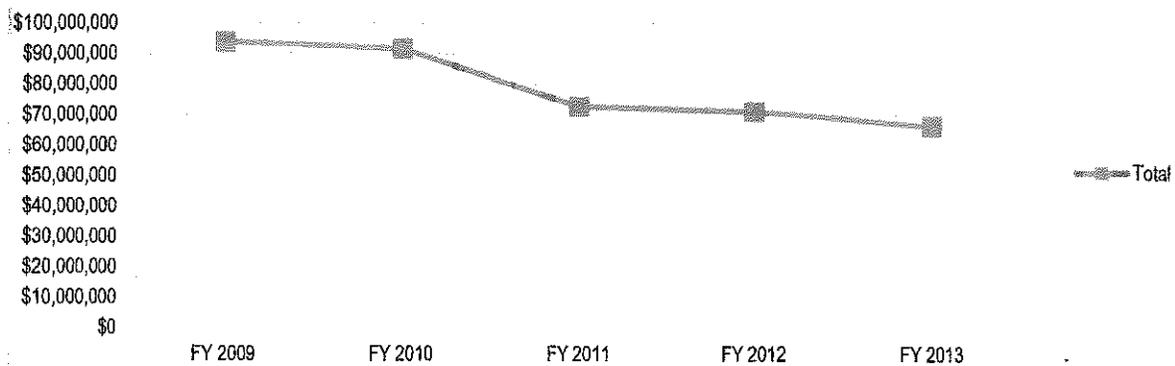
Figure 19

Mental Hygiene Administration (MHA) Summary



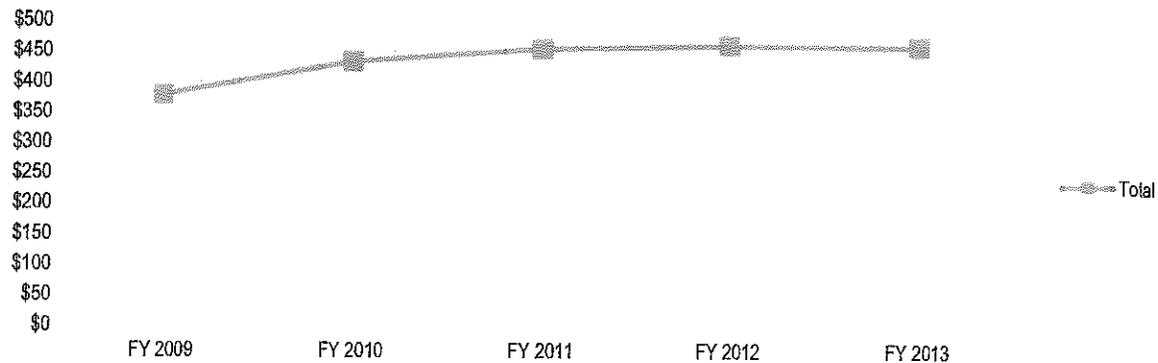
MHA Placement Trends							
Subcategory	1/31/2009	1/31/2010	1/31/2011	1/31/2012	1/31/2013	Average Change	Last Year Change
Diagnostic Evaluation Treatment Program	0	0	0	0	0	NA	NA
Juvenile Detention and Commitment Centers	0	0	0	0	0	NA	NA
Non-Secure/Non-RTC	0	0	0	0	0	NA	NA
Residential Educational Facilities	0	0	0	0	0	NA	NA
Residential Treatment Centers	534	482	440	371	393	-7.1%	5.9%
Substance Abuse and Addiction Programs (ASAM)	0	0	0	0	0	NA	NA
Living Arrangement - Non-Community-Based	0	0	0	0	0	NA	NA
Total	534	482	440	371	393	-7.1%	5.9%

Figure 20



MHA Non-Community-Based Total Costs							
Subcategory	FY2009	FY2010	FY2011	FY2012	FY2013	Average Change	Last Year Change
Residential Treatment Centers	\$94,033,805	\$91,629,633	\$72,649,911	\$71,180,664	\$66,348,547	-8.0%	-6.8%
Total	\$94,033,805	\$91,629,633	\$72,649,911	\$71,180,664	\$66,348,547	-8.0%	-6.8%

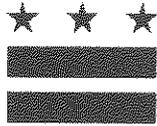
Figure 21



MHA Non-Community-Based Cost Per Bed-Day							
Subcategory	FY2009	FY2010	FY2011	FY2012	FY2013	Average Change	Last Year Change
Residential Treatment Centers	\$377	\$432	\$453	\$460	\$458	5.1%	-0.5%
Total	\$377	\$432	\$453	\$460	\$458	5.1%	-0.5%

These figures represent the Medical Assistance costs for all youth placed by MHA in RTCs divided by the number of bed-days (the total number of days in residential treatment for all youth placed in RTCs). These bed-day costs can vary due to utilization of RTCs whose costs which may be higher or lower than average due to different programming. RTC costs overall can vary year to year and have increased slightly over the past three years.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Youth Rehabilitation Services



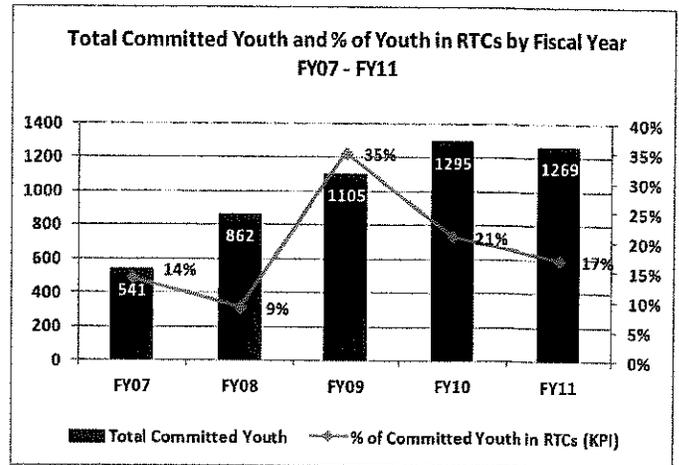
TRENDS IN DYRS RESIDENTIAL TREATMENT CENTER USAGE
In Response to the District of Columbia’s Behavioral Health Association’s
Sensible Budget Choices: Aligning DYRS Dollars to Youth Treatment Needs

Residential treatment centers (RTCs) and psychiatric residential treatment facilities (PRTFs) play an important role in the continuum of services at the Department of Youth Rehabilitation Services (DYRS). Serving DYRS committed youth with specific mental health, behavioral, or substance abuse needs, RTCs and PRTFs provide specialized treatment programs in a secure, structured environment.

RTC/PRTF POPULATION STATISTICS AND TRENDS

During FY2011, there were a total of 378 DYRS youth placed in RTCs/ PRTFs. Although this number has risen since FY2007, this upward trend primarily reflects the significant growth that has occurred in the overall DYRS committed population during that time. In FY2007, the overall DYRS committed population was 541 youth; by FY2011, this number had increased to 1,269.¹ This overall growth of the committed population helps explain the increase in the number of youth placed in RTCs and PRTFs.

On an average day in FY2011, 17% of DYRS committed youth were residing in an out-of-state RTC/PRTF.² This rate has decreased noticeably and consistently since FY2009, when 35% of the average daily population of committed youth were in an out-of-state RTC/PRTF. Due to this steady decline, the FY2011 levels are basically aligned with the 14% rate from FY2007.



¹ Population figures were obtained using DYRS’ case management database and are available in the DYRS FY2011 Annual Performance Report, located at <http://dyrs.dc.gov>. On February 14, 2012, the District of Columbia Behavioral Health Association (DCBHA) released a report entitled *Sensible Choices: Aligning DYRS Dollars to Youth Treatment Needs* (DCBHA Report). In determining the DYRS population levels and the number of youth in RTCs/PRTFs between FY2007-FY2011, the DCBHA Report makes estimates based on prior DYRS Key Performance Indicator (KPI) data which reflects the number of youth newly committed to DYRS, but not the overall number of youth under the agency’s supervision. These estimates inadequately reflect the significant growth that occurred in the overall committed population between FY2007 and FY2011.

² The percentage of youth in RTCs/PRTFs is reported in DYRS’ KPI data, which is available to the public at <http://capstat.oca.dc.gov/PerformanceIndicators.aspx>. This figure includes only out-of-state placements because the large majority of RTCs/PRTFs are located outside the Washington, DC metropolitan area, and those that are located within the District are different from typical RTCs/PRTFs in that they largely serve youth who are awaiting placement in another secure facility or who are returning home from facilities with higher levels of supervision.

Figure 23

Population by placement type

On any given day during FY2012, nearly half of all committed youth lived in the community, either at home or in a community-based residential facility, a foster home, or an independent living program.

Placement Types by Average Daily Population, Average Length of Stay, and Gender FY2012

		Average Daily Population	Average Length of Stay (days)	Male	Female
Community-based Placements	Home	256	172	91%	9%
	Community-based residential facility	105	60	95%	5%
	Foster homes	27	179	66%	34%
	Independent living programs	21	144	52%	48%
	Total	409			
Non-Community Placements	Detention center or jail	122	119	97%	3%
	RTC	139	189	81%	19%
	Model Unit at New Beginnings	51	218	100%	0%
	YSC/Awaiting Placement	41	24	179%	21%
	Sub-acute care	4	32	63%	38%
	PRTF	20	141	87%	13%
	Total	377			



Figure 24

In addition to reductions in the overall residential treatment center population, DYRS youth are being placed in facilities closer to home. Between January 2012 and December 2012, there was an overall 51% reduction in the agency's out-of-state residential treatment center population, with the greatest reductions being in the West (67% decline) and Midwest (67% decline).

DYRS Out-of-State RTC Population January 2012-December 2012

Region	January 2012 Population	December 2012 Population	Percent Decline
West	27	9	-67%
Midwest	60	20	-67%
Mid-Atlantic	80	45	-44%
South	20	18	-10%
Nationwide	187	92	-51%